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## ORIGINAL ARTICLES.

### MALIGNANT GRIPPE.

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Notwithstanding I have been keenly scrutinizing the literature relating to the subject of la grippe in its various forms, I have been able to find nothing satisfactory in the way of a clear exposition of the subject in all its details. And nothing at all treating of that particular form or phase of it which I denominate as above. By a clear exposition I mean that which gives not only a perfect description of the symptoms which may occur in the disease, but also a rational idea of the pathology, cause of death when death occurs, and proper treatment based on a thorough understanding of its pathology.

From time to time some mention has been made, in some of the journals, of symptoms of failure of heart and respiration which may occur, and which have occurred in individual cases belonging to the practice of different physicians, but which were promptly met and conquered by the use of digitalis, caffeine and strychnine.

But the typical case of malignant grippe has been ignored and the symptoms of heart failure have been considered only as incidental, and as liable to occur in any case.

Before I describe the typical case I will present a few cases not considered typical of the malignant type, yet in which the incidental complication of heart failure occurred.

Four cases of this character recur to my mind, but as I did not take notes, I shall have to give only a meagre outline of the symptoms.

CASE I. Female, æt. 62, a patient of my father, Irish, not very well nourished and a bad feeder.

There were the usual symptoms of invasion and the principal complication was a not very severe catarrhal affection of the lungs. She complained very little and did not seem to be seriously ill, when, on the evening of the fourth or fifth day, F— was sent for, messenger saying Mrs. K— was much worse.

Upon his arrival at 5 P. M. he found there had been progressive failure of respiration beginning at 3 o'clock. Patient was blue, respiration almost ceased; hands and feet blue and cold. The chest was immediately enveloped in powerful mustard plasters. Ammon. muriate to the amount of two drachms was stirred up in a bowl with hot water and a little whiskey, and the whole quantity given in the space of an hour, being teased down the throat a little at a time.

The patient reacted and ammon. muriate gr.v., was given every hour for several days, with whiskey and light nourishing food.

CASE II. Male, æt. 61. After several days illness in which there was the same complication of catarrhal pneumonia, but in which the lungs were perfectly pervious to air throughout their whole extent, symptoms of heart failure and also of the respiratory center came on. In this case whiskey and nourishing food was given, the stomach interdicting any great amount, and the result was happy as the patient got well.

CASE III. Female, æt. 91. After several days illness without any severe complications, only a mild catarrhal affection of the lungs being present, progressive failure of the heart and respiration came on, and despite all remedies and stimulants, patient died.

CASE IV. Female, æt. 73. Similar to first case, and same treatment was pursued, except the ammon. muriate was not given in so large an initial dose as one or two drachms, but was given for several days in doses of grs. v., every one or two hours. Result, recovery.

But there is an insidious and intensely malignant form of la grippe constantly among us, which not only is not recognized, but the symptoms and pathology of which have never been intelligently described.

This difficulty is increased from the fact that cases of it generally occur sporadically or between the seasons in which the epidemic shows itself. How easy it is, in nondescript cases of disease, to satisfy ourselves and the public by saying "it is a mysterious or anomalous case of malarial poisoning, or typhoid fever." Some time ago a physician writing from some place in West Virginia to a western medical journal, bemoans the fact that he has had seven cases of a mysterious disease, all of which have died.

No one ever attempts to classify these cases, they are simply dead to the attendant and to medical science. I am conversant with four similar cases which I shall denominate cases of "malignant grippe," all of which died and none of which were recognized as la grippe. As nearly as I can recollect, not having made notes of the cases, I give a short description of their symptoms.

CASE I. Female, æt. 38; a very near relative of mine. It happened in March, 1891, four or five weeks after the general epidemic for that season had ceased, and everyone had begun to forget all about the disease. The patient was two or three months pregnant, and had been very much run down by previous hard work and mental worry. Was taken with a diarrhoea early in the morning; was weak and miserable. Got up later in the day but the trouble increasing, a doctor was sent for. The diarrhoea became dysenteric in character, and did not respond much to remedies. Finally the bowels became

somewhat checked, when vomiting began which became uncontrollable, and in twenty-four hours patient was in a state of collapse and almost given up to die.

Patient reacted and I saw her in the evening about the fifth day from the time she was taken. The bowels were then under control, but she was retching all the time, putting her fingers back in her throat and attempting to vomit despite all remonstrance.

She seemed aware of my personality, but appeared to be in a dazed semi-conscious condition. Pulse was 90 and seemed good, temperature much above normal.

All they were giving her was very poor champagne, one-half teaspoonful, Bovinine gtt. xx, every half hour. I went to bed in the next room, directing that I should be called at 6 o'clock. Was called at 6 A. M., found the patient pulseless, unconscious, with high temperature and commencing to abort.

She died at 3 P. M., stimulants by mouth and under the skin apparently having no effect.

CASE II. Female, æt. 28; happened in the following, Summer in this city. Was attended by a friend of mine. It came on in very much the same manner with a dysenteric discharge and ending with progressive failures of the heart and respiration. Diagnosis 'Malignant Typhoid.'

CASE III. About two months ago, male, æt. 29, nervous hysterical temperament and with latent tuberculosis, was taken with all the preliminary symptoms of grippe. Pains in back and limbs and chill.

Patient took some cathartic pills and had two free evacuations. Kept at work for one or two days and then quit and sent for me.

I saw him in the evening; temperature 104°. Gave him hypodermic of morphia and atropia and sent him to bed. I had been attending a typical case of typhoid fever a few squares away, and could not disabuse my mind that this was a case of typhoid.

Accordingly, treated him the first few days in a mild antiseptic manner.

The next morning the temperature was down and for several days ranged not over 102°, running down to normal and sub-normal in the morning. Patient did not seem very sick but was very nervous and

could not sleep at night. There was not much if any localized tenderness of the abdomen, but complained occasionally of a general uneasiness, and there was the first few days a good deal of rumbling and borborygmus. Complained pretty constantly of pain over the region of the liver. Bowels were obstinately constipated, notwithstanding the use of enemata and calomel.

About the seventh day, the patient vomited his milk undigested and with every successive amount of milk ingested complained of nausea. Vomiting continuing, chicken-water was substituted for the milk, given in tablespoonful doses every half hour with the addition of whiskey. All this time the pulse has been full and fair, becoming somewhat softer with the progress of the case. Temperature ranging from normal to  $102^{\circ}$ – $103^{\circ}$  F. Vomiting continued at intervals, but was not very bad. On the morning of the tenth day the pulse went up to 120, which was the first real sign of impending danger. Distressing hiccough set in and continued until death. In the afternoon he vomited a quantity of thin, black fluid which had a peculiar smell, which, though it could not be called faecal exactly, yet somewhat approaching that odor at times, while at others no faecal odor could be detected and it had simply a pungent, sweetish, bilious smell. Pulse continued to go up and vomiting continued, the ejecta being thrown up and spit out without any particular effort of the patient. Respirations increased and patient died at 2 A. M., eleventh day.

Two things were noticeable in this case: An anxious look, and peculiar deep respirations somewhat similar to those which occur in the pyrexia of typhoid, although there was no fever to account for them; these were both present from the beginning.

CASE IV., in a female, set 62, rather delicate organization; happened during the last blizzard, beginning Feb. 12th, and ending Monday, 20th. A period abounding in piercing, damp winds from the west which were rendered still more discomforting by being charged with the moisture from large areas of melting snow,—an atmosphere peculiarly conducive to the development of grippal poison. This period is the longest in my knowledge, in which the wind has had that pe-

culiar blizzard-like quality, finding its way into the houses even up to the fireside.

Patient was taken sick Monday, 13th, with the usual symptoms of grippé: Slight chill, pains in the back and limbs, bilious vomiting, general soreness. A few grains of quinine were given, and the trouble was attributed only to a slight cold. Upon special request patient was persuaded to keep in bed the next day; temperature  $102^{\circ}$  F. For the next few days temperature ranged from normal to  $102^{\circ}$ – $103^{\circ}$ ; some days hardly going above normal.

Slight nervousness and inability to sleep were the only symptoms complained of. The patient did not consider herself sick, and insisted every day in getting up. Took a fair amount of nourishment. About the fourth or fifth day, had nausea and sick stomach and vomited once or twice. Insisted upon taking some citrate of magnesia, as the bowels had been obstinately constipated. She took some and the bowels moved three times, the discharges being ordinary yellowish in color; this contained undigested milk and smelled badly. Saturday evening, the seventh day, patient having a desire to evacuate the bowels, got out of bed, contrary to orders, to use the chamber and after a free evacuation collapsed and became apparently lifeless. Was returned to bed, rubbed with hot whiskey, hot bottles applied and, after a time, reaction set in. Pulse went up to 120 and temperature  $105^{\circ}$ . Ninth day, Sunday, temperature reduced, pulse gradually increased, respirations quickened and the patient began to vomit the characteristic black vomit, which came up without much effort being spat out very much in the same manner as in yellow fever. Pulse and respiration increased and patient died 3 A. M. the morning of the eleventh day.

#### REMARKS.

Several of the above described symptoms might be more particularly pointed out as differentiating the above condition from anything with which it might be confounded.

The typhoid condition is the one with which it probably is the oftenest confounded, although why it should be is hard to see, as there is no manner of resemblance between them. Constipation generally takes the place of diarrhoea, and when the



latter occurs, it is generally the result of taking purgatives and resembles in no respect the characteristic yellow typhoid stool. There is no marked tenderness over the ileo-cæcal regions, but instead you have marked and persistent tenderness over the liver. The fever range is characteristic and different from either intermittent or typhoid. It may run anywhere from normal to  $105^{\circ}$ , but often in the gravest cases does not go over  $103^{\circ}$ , and it has no regular time for remission or intermission. There is wanting the typhoid facies and often the face shows little or no anxiety or concern.

The tongue shows absolutely no indication of a typhoid condition, but in some of the gravest cases is moist, soft and clean up to a short time before death. Headache and inability to sleep are marked symptoms.

#### PATHOLOGY OF MALIGNANT GRIPPE.

Now a word as to the pathology of the disease, and this is a very important consideration in the discussion of any disease condition, for it is only by possessing a rational idea of the pathological condition that we can hope to intelligently direct treatment. What is the cause of the tendency to failure of heart and respiration? It may be the action of the disease poison upon the nerve centres directly, but taking all the different features of the disease into consideration the following seems to us to be a more probable explanation of this unfortunate tendency.

Every one who has at all studied the disease has noticed the fact of the existence of an abnormal condition of the mucous membranes of the whole body. The alimentary canal, from the mouth to the anus, seems to be in a parietic condition, and digestion is for some time almost *nil*. The liver and excretory organs also seem to be functionally at fault. This condition could be produced either by a disturbance of the vasomotor system supplying the absorbent, digestive and excretive surfaces, interfering with their proper nutritive supply, or to a direct action on the nutritive nerves which supply these surfaces or areas, the only additional conceivable conditions being a direct anatomical change in the tissues themselves.

As the result of one or more of the above conditions, we have the terrible outflow of Asiatic cholera, and in almost all

cases it is secretion or excretion in excess or obedience, that works the death of the patient. In this case the latter prevails and, between the impoverished condition of the blood and possibly the direct poisonous action of the disease germ, we have necessarily impaired nervous energy in the vital centers with consequent death.

There remains much to learn in regard to the pathology of this mysterious disease, but in the meanwhile, in the name of all the humanities and the dignified science of medicine, let it be recognized, and not in the contentment of ignorance call it malaria, typhoid, remittent, etc.

For until a condition is recognized how can we hope to intelligently cope with it. It is like fighting in the dark with a foe we know not of.

#### TREATMENT.

This explanation furnishes also a rational method of treatment and proves the correctness of that which has been followed by success. If a sufficient amount of food and stimulants can be absorbed, the patient will get well, if not he will die. Alcohol in some cases has seemed invaluable, in others of very doubtful value if not positively harmful.

Quinine, except in the earliest stages, is a very doubtful remedy and must be handled with the greatest care. In many cases it is doubtful whether it does not do more harm than good by increasing the tendency to cerebral congestion. Antipyrine, antifebrine, phenacetine, *et id omnis genus* are very doubtful remedies and it is like playing with fire to handle them. You don't know what minute you are going to have a case of collapse and then the agonizing question comes up, is it the effect of the disease or the medicine added to the disease?

In many cases very little food is taken or digested for days, and in those cases lemons, oranges, apollinaris, ice and whisky seem to do much toward keeping up the strength.

The infusion of digitalis has seemed to commend itself to me. I have used it in a few cases and intend to try it further, giving it early in the disease with a view of possibly averting the tendency to congestion of the mucous surfaces, by contracting the small vessels and at the same time producing its tonic effect upon the heart. But the medicine of all others,



that has commended itself to me in the general run of grippal cases, is ammon. muriate given often and kept up for a long time.

Especially is it useful where there is catarrhal trouble of the lungs, and it is well to combine it with whisky where this agrees with the patient.

In this day and generation, in the effort to supply a satisfactory reason for all things many important therapeutical points are lost sight of entirely. What matters it how a medicine acts if it has the desired effect? The salts of ammonia have suffered in this respect with other valuable remedies. That they have a powerful effect in stimulating the secretive and

absorbent system no one who has practised medicine for forty years doubts. If you have got to wait before using them until you find out exactly how they influence those systems, your patients may all be dead, in the graveyard and the muriate will remain still on your shelves.

One of the most remarkable things about the most malignant cases, is that there is very little lung complication, but the full force of the disease is thrown upon the alimentary canal. I have seen one case where there were marked symptoms of meningeal trouble and congestion at the base of the brain. A fly blister at the nape of the neck gave immediate relief.

## CLINICAL LECTURES.

### RETARDATION OF BRAIN DEVELOPMENT: GASTRALGIA: DEFECTIVE NUTRITION: LOSS OF MEMORY.

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GENTLEMEN: This little girl is seven years of age, and we are told that she appeared to be healthy up to the time when she learned to talk. At present, her mother says, she does not talk any more than a child two and a half years of age. She is a mouth-breather. From the fact that she has some affection of the Eustachian tube and middle ear, she does not hear as readily as she ought. When a year and a half old she fell, striking on the top of her head. We do not know whether her present condition is due to that fall or not. There might have been a slight hemorrhage at that time which affected the centre of speech. However, it is a case in which the probabilities are in favor of an injury having been received by the brain at the time of the fall. Furthermore, we are told that the child fell over the bed on to the floor, striking upon its head. The presumption is, under such circumstances, that there was an injury sustained by the brain. She escaped without serious apparent injury at that time, nevertheless that does not

detract from the fact that a fall upon the head is a dangerous thing.

We cannot always discover the full extent of the injury that has been received at the time of a fall or blow. A little child came once under my observation, that fell backwards off the first step in front of a house, striking the hind part of the head. The injury, at the time, did not seem very severe, but the child died three months afterward with cerebral symptoms. On making an autopsy a fracture at the base of the skull was found. Another child standing on a chair, fell off upon its head and had hemiplegia as a consequence, which was the result of a rupture of a blood vessel. We could go on multiplying illustrations of the dangers that may be induced by a comparatively slight blow or fall striking upon the head.

In the case before you the injury seems to have produced retardation of development. A slight inflammation—not enough to involve the brain in great danger, but modifying its nutrition and producing a slight local inflammation of the membranes—interfered in some degree with the development of the cortex I

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am speaking now of slight causes that are insufficient to produce characteristic fever, general prostration, compression and death. As a consequence of such meningeal inflammation it is a very minor degree of damage that has been inflicted, but when it involves the cortex of the brain it is sufficient to retard development and to interfere with the acquisition of speech; the child remains permanently backward, and is of a lower intellectual order than it would be under ordinary circumstances.

The child does not talk as much as other children, though that may be due to partial deafness. When a child cannot hear well, it is difficult for it to acquire language. It is an obstacle in the way of rapid intellectual progress. The difficulty of hearing is associated with the difficulty in breathing. There is a narrowing of the nasal passages so that the child is obliged to breathe through its mouth. We have a chronic inflammation involving not only the nasal passages, but the Eustachian tube. It has produced a sub-acute or chronic inflammation that interferes with hearing.

The treatment of this case should be relegated to the care of a aurist. The patient should have such operation performed as is necessary in order to breathe freely through the nose, the inflammation of the Eustachian tube and ear being remedied at the same time. This being done the child will doubtless progress more rapidly, and the brain and all the intellectual faculties will be much more readily educated.

#### GASTRALGIA.

This seems to be a case in which the complaint is principally gastralgia. The patient is a tolerably well nourished man, married, and has a considerable family of children. He says he does not indulge excessively in sexual intercourse, so that the pain cannot be ascribed, as in many cases it can be, to sexual excesses. There are many patients who complain of gastralgia before they commence to eat, when the stomach is empty. You will find in certain cases it is due to sexual excess, but sexual excess has no further relation to the establishment of such a pain than any other form of excessive exertion. You may meet with the same difficulty in persons who sit up late at night and who

do not get enough sleep; in persons who are irregular about their meals, or whose business is such as to cause a great deal of mental anxiety. These are likely after a time to have vague, ill-defined pain located about the epigastrium. You can hardly tell whether it is in the back or side, so generally diffused is it.

This sort of pain is best relieved by removing the cause. If you can get sleep enough for the patient, can regulate his habits of eating and drinking and sexual indulgence, you will, I dare say, without the use of medicine, secure perfect relief. A valuable means for the mitigation of pain is the administration of a little food, a crust of bread, when an attack comes on. I will relate a case in this connection:

A man suffered with gastralgia and found accidentally that a glass of milk would relieve him of the pain, so accordingly he began to drink milk. When the pain came on he would drink milk, but finally the attacks became so frequent that he carried a bottle of milk in his pocket, and kept drinking it every few minutes until his stomach became enormously dilated, and constantly distended with curd, so that this evil was as great as the first.

You must not rely only upon such simple palliatives. You must find out the cause and govern your treatment accordingly. Patients who use much tobacco suffer with gastralgia, and so do excessive tea or coffee drinkers, after a time. It is a common thing for dress-makers—who go from house to house, who are rather irregular in the matter of eating and drinking and their habits of living, who live poorly on some days and on other days live well, who keep irregular hours—to go home late at night after a hard day's work, and make strong tea and drink several cups of it. They poison themselves with the tea. Headache and gastralgia come from the tea and coffee taken in excess. You must urge them to give up drinking such beverages. It is the opinion of some that the excessive use of tea or coffee produces as much personal misery as the alcoholic habit itself.

This patient says that he smokes from eight to ten cigarettes a day. He is a tailor, and people with sedentary occupations suffer most severely with difficulties of this kind. There is a belief that cigarette smoking is worse than ordinary cigar

smoking. I do not know why that should be so if the quality of the tobacco is the same. We will instruct this patient to discontinue cigarette smoking, to change his habits of exercise, and to go out of doors more, and he will probably improve. To benefit his digestion he may take one quarter of a grain of extract of *nuxvomica*, three times a day, and with it a grain of the extract of gentian. During the paroxysms of pain it may be well to add a grain of *hyoscyamus*, to be taken three times a day before each meal. A tenth of a grain of *aloïn*, or of *podopyllin* may be added if the bowels are constipated.

#### DEFECTIVE NUTRITION.

This boy is fifteen years of age. Three weeks before Christmas, he began to have pain in his stomach. He is and always has been delicate. When two years and a half old, his mother says "he caught cold in the spine and was helpless for seven weeks." He could use his arms, but not the lower extremities. When three and a half years of age, he had cerebro-spinal meningitis, and was laid up three weeks with it. He has complained of headache ever since. His appetite is good, but occasionally he vomits his food. He has had steady aching pains in his joints.

Notice the appearance of the patient. His head is peculiarly formed. Observe the prominence of the scapulæ. There is not perfect retraction of the scapulæ when he attempts to draw the shoulders back. The shoulders lap forward a little. The muscles are full but soft, showing that they are not in a state of contraction. It is not natural for a child's shoulders to droop forward in the manner which you see in this patient. It shows a general weakness of the muscles. The *serratus magnus* muscle should contract vigorously, and should hold the scapulæ firmly against the thorax. It does not act as it ought to. A chronic weakness is apparent in the abnormal prominence of the scapulæ. The bone is not adapted to the trunk as it should be, yet there does not seem to be actual paralysis present. The vertebrae are a little irregular, and their abnormal position gives to the patient a very hollow-chested appearance, which is fictitious rather than real, being caused by the great prominence of the shoulders

rather than by any actual falling in of the anterior thoracic wall.

These symptoms we may account for in part by the attack of cerebro-spinal meningitis which the patient had when he was three and a half years of age, and it is very probable that the nerves were then so damaged that they have not since been able to convey proper trophic impulses and tonic influences to the muscles, so as to keep them in a healthy state; yet there is no complete paralysis. It is damage not destruction, that has occurred.

The pain experienced is very irregular and widely distributed; he also complains of tenderness on pressure. The vaso-motor nerves are deficient in tonic power. When I drew my finger over the front of the chest (left side), it was followed by the appearance of a purple line on either side of it. The same appearance can be had on the right side. That is consequent upon a sluggish action of the vaso-motor nerves that control the circulation of blood in the skin. It is not an evidence of any specific disease, or of any particular condition other than that of general vaso-motor exhaustion. It occurs in various disorders. You see it in the introduction of measles, scarlet fever, tubercular meningitis and diseases generally exhaustive in character. The mother says he wets his bed at night, which is another evidence of nervous irritability. There is nothing characteristic about the respiratory sounds.

The patient does not have the appearance of one who has chronic renal disease. In that disease there is a peculiar pallor. I should hardly expect to find renal disease in this case, but still the urine ought to be examined to ascertain whether there is any disease of the kidneys, and examination shows it to be normal.

The joint troubles are of the nature of aching pains without swelling. You will frequently hear patients complain of "growing pains." "Growing pains" are simply neuralgic pains felt about the joints and sometimes in the muscles of different parts of the body. Sensitive nervous children are liable to neuralgic pain. When it is really rheumatism, it declares itself in the form of difficulty of moving the muscles, a cramp, a torticollis, or something of that kind.

This patient has a slight chorea. There is a little nervous twitching about the



arms. The mother further tells us that he has no desire to sleep. There is no history of rheumatism in the family, nor of tubercular disease; no scrofula, and no eruptions upon the skin. Those facts militate against hereditary syphilis and scrofula.

We do not succeed in putting our fingers upon a definite single lesion or disease, but must take the case as one in which there is a general disorder in nutrition and, consequently, deterioration of health. The shape of the patient's head alone is sufficient to indicate it. The undue prominence of the forehead and the bulging aspect of the head itself are sufficient to mark the case as one of defective nutrition. It is not severe enough to constitute "rickets." There are no syphilitic manifestations. We have evidences of imperfect development of growth and nutrition of the body at large. The history of feeble digestion points in the same direction. When children grow up with bad stomachs it is not to be expected that they will mature normally and healthily as other children do.

Then it is well to observe the expression of countenance. You see how this boy keeps continually wrinkling his forehead. When you see that you inquire into the condition of the eyes. It is due to eye strain sometimes. The patient has difficulty in fixing the eyes upon certain objects. His eyesight is poor. He should have his eyes properly attended to by an experienced oculist, and all defects of vision should be corrected. A large number of these cases are due to a malformation of the skull. Persons with perfectly formed skulls do not have bad eyes. When there is an imperfect development of the skull, there are deformities of the ocular globe. The patient, for instance, may be astigmatic, a condition which interferes with easy, distinct vision. This wrinkling of the forehead must be corrected by proper glasses. Many a child suffers with headache when it has uncorrected ocular defects. Many of these defects can be very much aided—in fact, entirely relieved sometimes—by the use of proper glasses, but it requires careful observation and special delicate adjustment to get glasses that will exactly correct the errors. I know this from my own experience when I commenced to wear glasses a few years ago. I found

that a single examination was not enough, that it was necessary to make repeated examinations to correct the defect. Even the oculist himself cannot always tell the exact amount of correction that is necessary. The states of the eye vary from day to day. What is sufficient to-day won't be sufficient next week; so much depends upon the transient states of the nervous system, the amount of tone in the muscles, and the amount of vigor in the nerves which vary from day to day and from week to week; but with intelligent assistance on the part of the patient the oculist can usually succeed in correcting the defect; and the comfort that proper eyeglasses give to such persons must be experienced in order to be thoroughly appreciated.

Now, a great deal can be accomplished for the relief of this patient by proper adjustment of glasses for his eyes; then he must be treated on general principles to invigorate his general health by assisting digestion. The patient must be placed under the most favorable conditions for nutrition, and then little by little, he ought to improve and gradually outgrow many of his defects. Associated with this treatment should be properly arranged methods of gymnastic exercises with dumb-bells and pulley weights, that will expand the chest and invigorate those muscles that throw the shoulders back.

#### LOSS OF MEMORY.

The next patient, a woman, is forty-eight years of age. Nine years ago she was confined, got up within a week and went about her household work for two or three days; then she went to bed and lay there for six weeks in a stupor. She did not have sense enough to nurse the baby. Her parents had to feed her. She has had two children since then, but no such profound stupor. Sometimes, however, she will sit and stare for a long time at nothing. She is weak and now unable to do her housework, and is steadily growing worse. Occasionally she has lucid intervals. She was born in Scotland, and left that country when nineteen years of age. She does not remember the number of the house nor the street she lives on.

A peculiarity which is quite apparent in many cases of deterioration of the memory, is that patients remember incidents of their early life better than those of re-

cent occurrence. The same is true with this patient. She remembers the place where she was born, and of coming to this country when nineteen years of age; but she is not able to give an account of recent events. She is unable to tell us the number of children she has. That is a very interesting characteristic of loss of memory which is dependent upon deterioration of the brain. We see it in a more or less marked degree in all elderly people as they advance in years. Their memory of early life is perfect, but the events of last week or last year are almost forgotten. It is difficult for many elderly people to remember or talk of things that have occurred within the last five or ten years.

Dr. Rush tells us what he observed in the epidemic of yellow fever in Philadelphia, 100 years ago. He had an immense practice and saw a great many patients. Among them were many Swedes who had lived for many years in Philadelphia. Having migrated to this country in early life, they had learned to speak English and consequently had almost forgotten to speak their native language. For fifty years or more they spoke English. He noticed that those old people who were stricken with yellow fever would recount incidents in the Swedish language, a language which they had not used for many years. It seemed as if their experiences or impressions of later life had been obliterated and that original impressions came once more to view. When, by age or by certain diseases deterioration of the function of the brain is manifested, the loss of memory shows itself in this way. Then again, the loss of memory declares itself in regard to the names of things and of persons.

With regard to action, it is something that is bound up in our nature. We form habits of walking, of seeing, eating, drinking and of daily life. Our professional occupations become habits that are ingrained in our nature. These things we do not forget as we do the names of things that are arbitrarily fixed. An apple is a sort of sign to designate a certain thing. When the brain becomes deteriorated by disease, and an apple is presented to the patient, she cannot tell you what it is. She has forgotten the name of it. If you let her take the apple in her hand she has not forgotten that it

is good to eat. She has not forgotten the action suggested by the sight of the apple. The name goes first, but the action that is connected with the thing is not forgotten. These peculiarities are characteristic of a deteriorated brain, which seems to be the case with the patient before us.

There is some grave disease involving the brain. Nine years ago when the patient gave birth to a child, she passed into a stupor and remained in that condition for six weeks. Whether she had puerperal fever or toxæmia, or not, we do not know. It is not improbable that there may have been some toxic influence operating on the brain that produced the state of stupor that persisted. We know conditions of toxæmia do produce such stupors. It is observed that in certain old cases of cerebral syphilis, patients pass into a state of stupor, the conditions of the brain being induced by various causes of a cachectic character which we do not understand exactly. But the patient is in a cachectic condition and may lapse into a state of stupor and remain in that condition for weeks or months.

Dr. Gardner, of the Glasgow University, has recorded a case in *The London Lancet*, of a woman who remained in a state of stupor for three months, then she emerged from it the same as this patient did. During all that time it was necessary to feed her with a spoon. There was some twitching of the eyelids, and the patient appeared as if she knew that persons were near her. She knew her husband when he came to see her, and manifested her consciousness of his presence by certain motions of the eyelids. But consciousness is absolutely and entirely obliterated in many of these cases. As a consequence of such disorder of the brain cortex having remained after the patient recovers from the state of stupor, it is very apt to leave the brain in a permanently deteriorated state, and the patient may lapse suddenly or gradually into what is called *terminal dementia*.

Dementia is a state in which the patient has perhaps good general health, but the thinking power of the brain is pretty much abolished. The patient lapses into a state approaching that of an animal that is deprived of its cerebrum. The degrees of dementia vary with the profundity of the lapses from the normal standard of

health. That seems to be the case here. The patient is not, perhaps, entirely demented, but is on the way towards terminal dementia.

These cases are also very intractable. It is difficult to cure them, yet they can be relieved, if not entirely cured, sometimes. The method to pursue is forcible feeding. When they are in a state of stupor it becomes necessary to feed them artificially. They must be fed with milk, egg-nog, and every kind of food that can be made into a thin paste. It is necessary to feed them in this way sometimes for weeks or months. In addition to forcible feeding, they must be stimulated, and the stimulation which comes from electricity is of a useful character. They may

be sometimes aroused by it and saved from the condition of terminal dementia which is almost inevitable otherwise. These cases are hopeful if you can get them to take nourishment in large quantities; especially if, in addition to taking nourishment, they improve in flesh. But, when a patient is conscious and has suffered in this way for nine years, it is doubtful whether complete restoration to health can ever be secured; still it would be advisable to feed her well, to administer arsenic, phosphorus and strychnine. These three agents, which promote nutrition and increase the circulation of the blood in the cortex of the brain, would be useful in this case. A long course of such treatment might produce a good effect.

## COMMUNICATIONS.

### PARALYSIS OF LARYNGEAL MUSCLES, WITH CASES.

WM. CHEATHAM, M. D.\*

The larynx has nine muscles, four pairs and a single. Besides these there are three pairs belonging to the epiglottis—the thyro-epiglottis, inferior aryteno-epiglottis, and the superior aryteno-epiglottis. The posterior crico-arytenoides widen the aperture of the larynx. The crico-arytenoides lateralis and the arytenoides, assisted by the muscles of the epiglottis and the ary-epiglottis, close the aperture of the larynx. Those governing the pitch of the voice are the crico-thyroides, assisted by the crico-arytenoides postici, making the cords tense. The thyro-arytenoides externi shorten, relax and bring the vocal cords together.

The nerves of the larynx are the superior laryngeal and the inferior or recurrent laryngeal, both branches of the pneumo-gastric. The superior laryngeal supplies the mucous membrane with sensation and the crico-thyroid, the thyro-epiglottic and the ary-epiglottic muscles; the other supplies the other muscles; the ary-tenoides receiving fibres from both.

Neuroses of the larynx may be either sensory or motor. Those of sensation may

be anæsthesia, hyperæsthesia, paræsthesia and neuralgia.

Gottstein and Lefferts have given a clinical classification of paralysis of the muscles of the larynx, and Mackenzie a pathological one.

I have seen cases of paralysis of the recurrent laryngeal unilateral and bi-lateral, of the adductors unilateral and bi-lateral, of the abductors unilateral and bi-lateral, and of the arytenoides.

One case of hysterical paralysis of the adductors, which I believe I reported to this society before, was in the person of a merchant from one of our interior towns. As in most similar cases the muscles of the lips were also involved. A strong interrupted current with one pole in the larynx soon restored him his voice. I have seen several cases in females; some of them hysterical and some catarrhal. Rheumatism may produce it or it may be toxic in character, depending upon lead or arsenic; lead here affects the adductors alone as it does the extensors of the forearm. Anæmia is a common cause. I have seen some times persistent, but more often intermittent, paralysis of one or both adductors in cases of lung phthisis, lasting

\*Professor of Diseases of the Eye, Ear, Throat and Nose, Louisville Medical College.

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for several years. Diagnosis is usually easily made with the laryngoscope. Prognosis in adductor paralysis is usually favorable. Emotional influences give relief frequently. A brush applied to the larynx or sometimes the simple act of laryngoscopic examination gives relief. Mackenzie cites in his book a case taken from Herodotus, who speaks of a son of Croesus who was dumb, but whose voice was restored when some one not recognizing his father was about to kill him.

Paralysis of the abductors is a much more serious matter. Here we have the "Gate of life" about to be closed. The cause may be neuropathic or myopathic. In three cases seen by Mackenzie during life, changes were found in the muscles after death, while the nerves and brain were normal.

My object in presenting this paper this evening, is to report four cases. One positively paralysis of the posterior crico-arytenoides; another I am not so positive of, as it is in the person of a child but six months old, rendering a laryngoscopic examination almost impossible; and two cases of paralysis of the recurrent laryngeal nerves the result of large aortic aneurisms. The last two cases mentioned died in a few days after I saw them, of rupture of the aneurism. In these cases no operative interference was indicated as the cords took the "cadaveric position" in which voice is partially lost but respiration not much interfered with. These are all the cases of this trouble I can recall as having seen.

The child referred to above was brought to me about one week ago. The mother said it had had the trouble all its life. As I stated before, the child is but six months old and its only trouble is on inspiration; expiration is perfectly free; symptoms worse when asleep. The noise it makes then in breathing can be heard all over the house. Its cry and crow are natural; it has no trouble in feeding; the mother says it is as healthy as any other child. After several efforts I could see the epiglottis and the vestibule of the larynx; the epiglottis is an exaggerated omega shape; I could discover no growth of the larynx. A growth of the larynx could give about the same symptoms. I have seen two similar cases in babies, or cases with similar symptoms, which were relieved by pulling the tongue well out, or

by holding the children with their faces down; both of these children had trouble in nursing; this child has none. The present symptoms are those indicative of paralysis or paresis of the cord abductors. I have never heard of a congenital case unless this is one. Some one may suggest anaesthesia for a laryngoscopic examination. There would be great danger attending it and any one undertaking it should be prepared for an intubation or a rapid tracheotomy.

The second case is in a woman forty-five years of age, otherwise healthy; she has been examined several times by different doctors and no cause for the adductor paralysis discovered. The trouble has been coming on for months; she has been treated for hysteria, so she says, having taken a gallon or two of asafoetida and valerian; the breathing is so bad at night that policemen have rung the family up and asked if any one was being murdered. When she came to see me about six weeks ago I found expiration free, but inspiration very difficult; voice not much affected; she had had electric and other treatment with no relief. Symptoms made worse by exertion. The laryngoscope gave a perfect picture of paralysis of the post-crico-arytenoides; the cords were nearly together; the chink enlarged somewhat on expiration, but nearly closed in inspiration; the shape of the cords, and the difference in the rarity of the expired and inspired air accounts for this. I suggested that she again try electricity and add to it hypodermatics of strychnia nitrate; she reported in a few days with her trouble much increased, the cords looked some thickened and red; her lips were a little blue; she could not sleep well but while talking to any one she would fall asleep. Believing the case now to be quite a serious one I suggested to the family either intubation or tracheotomy; they, of course, preferred the former.

This narrowing of the glottis leads to much damage in other organs. This interference of change of gases in the lungs drives the blood back to the right side of the heart, resulting in much damage to distant organs. Intubation was done four weeks ago. I inserted, with but little trouble, an adult hard rubber tube. Vulcanite is better for the adult tubes, especially when used in such a case as this, as there is no membrane to plug them consequently not so

liable to be coughed out, weight to prevent it not being necessary. Calcareous deposits are not as liable to form on them, consequently they can be worn longer without a change being necessary; the weight being so much less, they are not liable to irritate the vestibule. The patient complained a good deal of the tube for several days; said she now gets too much air. There was some soreness on swallowing for a few days. Temperature for four or five days was 100. To-day, Feb. 21st, temperature is normal; there is but little soreness on swallowing, and she says she sleeps better than for months; all drowsiness has disappeared, and color is good. She says she feels like a new woman; she eats solids and semi-solids sitting erect, but has to take fluids with chest lower than the rest of the body.

What is the future of this case? I am inclined to use the intubation tube as long as it can be worn, changing the tube for cleansing and to utilize new points of pressure every four, six or eight weeks, by this hoping in some months to get the cords fixed in the "cadaveric position," or if this can not be done to nick or cut through each cord, then put the tube back. Whether or not this can be done without a preliminary tracheotomy I cannot say. I will of course try it later on. I know of no measure of relief that will not destroy or partially destroy the voice. With the tube in position the patient can now make herself understood across a large bedroom. I believe then that the patient can, should no accident occur, by opera-

tive interference get free breathing with partial loss of voice. No book, that I know of, speaks of intubation for the relief of this difficulty. Tracheotomy is advised. Intubation has been successfully used in similar cases by O'Dwyer and others. Dr. O'Dwyer for one of his cases had a cylindrical tube made so as to get more lateral pressure.

These cases are fortunately rare. A majority of them die of their own neglect, refusing operative interference, and others of neglect of their physicians who turn them away as hopeless. A strange coincidence, if the baby's case is one of abductor paralysis, is that both cases live in the same neighborhood, within a square of each other.

Mr. President, while on the floor and speaking of paralysis, I would like to state that in the last ten days I have seen two cases of one sided mydriasis, one of the cases with myosis of the fellow eye, one case of right third and fourth nerve paralysis, one of left third nerve paralysis with atrophy of the right optic nerve, with some of the muscles of deglutition involved, and another with paralysis of the right third, fourth, fifth, and sixth nerves. I also have, besides the patient reported which promises to be a lengthy one for intubation, a child three years old, who has been wearing a tube twenty-three weeks for a growth of the larynx, the tube staying in at one time seven weeks without being changed; and a woman with phthisical laryngitis who has been wearing a tracheotomy tube for nine months with perfect comfort.

## TREATMENT OF BILIARY COLIC WITH GLYCERINE.

H. REASONER GEYER, M. D., NORWICH, O.

Surgeons are now removing biliary calculi and some successful cases have been reported.

Before so serious an operation is performed all therapeutical means should be exhausted. In many cases surgical interference is not necessary. A patient may have an attack of biliary colic and suffer severe pain, which may be relieved by therapeutical means.

I wish to call the attention of the pro-

fession to a remedy which I have been using for the relief of biliary symptoms, and to report the following cases treated with *glycerine*.

CASE I. Mrs. H.; widow; age fifty-three; of stout build. The patient has given birth to six children. Health good until menopause, which occurred at the age of forty-five. Since then patient has suffered more or less with various troubles. In January, 1891, the patient had quite a

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severe attack which was diagnosed as biliary colic. Subsequently she has suffered recurrences at intervals of about six or seven weeks. Morphine had to be used quite freely to relieve the pain. I was called to see patient in July, 1892, and found her suffering with severe pain in the epigastrium, radiating to right side; also in the back near spinal column. Nausea and vomiting were present. I immediately gave her a tablespoonful of glycerine. The vomiting ceased and in ten minutes the pain was considerably relieved. Repeated the dose in twenty minutes, and in one-half hour from first administration, the patient was free from pain. When relief had been afforded, a severe rigor set in which lasted for some time. Ordered a teaspoonful of glycerine to be given every three hours. Next day the patient was able to be around, and without suffering from the headache and nausea which followed the use of morphine. There was marked tenderness in the region of the gall-bladder, liver somewhat enlarged and patient very much jaundiced. Stools of clay color. Ordered  $\frac{1}{4}$  grain calomel pellets to be given three times a day, until bowels moved freely. In ten days the icterus was gone and the patient well as usual.

In two weeks she had another attack, which I relieved with glycerine in the same manner as above stated. No more attacks occurred until Sept. 30. This was unusually severe. Renewed the glycerine as above described, and relief followed in thirty minutes. Then I ordered

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sig.—Teaspoonful three times a day.

This was given for a few weeks and now the patient is taking but one teaspoonful a day. Up to the present time, March 1st, 1893, there has been no return of the symptoms.

**CASE II.** Mrs. F.; age 66; married; has given birth to nine children. Health always rugged until menopause. For last ten years has had spells in which she suffered pain in epigastrium with nausea. Vomiting would generally end the attack. On November 4th, I found her suffering severe pain in epigastrium, radiating to right side, very much nauseated, and vomiting quite frequently. From the history of the case and the symptoms present, I diagnosed biliary colic. I

gave a teaspoonful of glycerine, repeating the dose in fifteen minutes, and in one-half hour the patient was free from pain.

As soon as the pain subsided the nausea ceased and the patient had a chill. Next day I found her much better; liver slightly enlarged and very tender to pressure in region of gall-bladder. No jaundice present, stools of clay color; senna was ordered to move the bowels and nothing further was given. Soreness remained several days. There has been no return of the symptoms up to date, a period of four months.

**CASE III.** Mrs. B.; age 57; mother of seven children; of spare build, but has always been very rugged. On December 15th, 1892, was called to see her, and found her suffering with severe pain in region of the liver. Nausea and vomiting present. Relieved her with glycerine as stated in Case 1. Next day found tenderness in the region of the gall-bladder. No jaundice, stools clay colored. No return of symptoms so far.

**CASE IV.** Mrs. W.; age 64; has given birth to seven children; sparsely built; always enjoyed good health. Has had what she called "cramp colic" several times. Was called to see her in January, 1893. Found her suffering severe pain in the epigastrium, very much nauseated and had vomited several times. Tenderness on pressure in the region of the liver. Relieved her with glycerine as stated in Case 1. Next day I found her much better. No jaundice present. Stools clay colored. Urine very offensive and high colored. Nothing further was given and the patient made a rapid recovery.

Dr. Albert Brubaker says that *Spasmodic Croup* in children, coming on suddenly at night, is often due to impaired digestion brought on by eating some heavy food just before retiring. If the stomach in these cases be emptied by an emetic, it will be found that the croup will also disappear.—*Cal. and Clin. Rec.*

Garlic is the latest remedy guaranteed to cure cholera. This ought to do it, sure! What well-bred and self-respecting bacillus of standing in the pathogenic fraternity could face such an enemy?—*Ex.*



## A CASE OF GONORRHOEAL RHEUMATISM.\*

A. M. VANCE, M. D., LOUISVILLE, KY.

The patient is a friend I have known for a number of years. Some five or six months ago, he came into my office walking with great difficulty, said he did not know what was the matter, his feet were badly swollen and very painful. I asked him if he had ever suffered an attack of gonorrhœa, and he said yes, that he contracted gonorrhœa about three months previously and had been treated by various physicians, by electricity, etc. I examined him carefully and made up my mind that he had a typical case of so called "gonorrhœal rheumatism." I informed him of this fact and he wanted to know what could be done for it. I gave him a very blue prognosis. He went over to French Lick for a week—as I advised him to take a little rest.

When he came back he went to Dr. Palmer, who cured the gonorrhœa so far as any special symptoms about the genitals were concerned, but his feet were no better. He then employed a homeopathic physician, stating that Dr. Palmer had given large doses of iodide of potassium which he sustained without any bad symptoms at all, and the second doctor told him that his experience was, that when a man could stand such large doses of medicine without any effect, one of the orifices of the body was at fault, either the rectum or the urethra. He examined the penis and finding that all right, made an examination of the rectum and told the man that he found several "folds" or "pockets" which should be removed. He was sent to the Norton Infirmary and the lower part of the rectum excised.

About three months afterward he returned to me, and I found him in even a worse condition than upon his previous visit. I told him that I could not possibly do him any good unless he would take absolute rest; that I thought if he would go to the infirmary for about sixty days, I could benefit him a great deal. He considered the matter for a day or two and finally consented. He went to the infirmary and I put on a pair of plaster boots reaching to his knees, and com-

menced giving him iodide of potassium. I want to state that he gave a history of syphilis in years gone by and I thought some of the trouble was possibly of a specific character. I gradually increased the dose of iodide of potassium until he took about 400 grains per day, and he progressed very favorably. I also gave him bichloride of mercury in 15th grain doses, keeping him in bed for about thirty days; at the end of that time I removed the plaster boots and found that his feet had returned to their normal condition so far as swelling was concerned. Tenderness had disappeared entirely in the right foot, but the left heel was still tender on pressure. I kept him quiet two weeks longer, and at the end of six weeks he is walking about and I think his ultimate recovery is assured.

The point of consideration in the case with me is, the kind of medicine to be used in these sub-acute and chronic cases of gonorrhœal rheumatism. I believe that iodide of potassium is the proper remedy. The disease is probably a plastic deposit around the nerves and the treatment should be directed to its absorption just as you would in chronic rheumatism or syphilitic deposits. The reason he responded so readily to iodide of potassium may be the fact that the trouble was partly syphilitic in origin, but I have had the same result in other cases where there was no specific element.

The Provident Bounty Association, of London, has published a prospectus recommending itself to the patronage of all families, and especially to that of young married couples. Its object is to insure married people against twins and triplets. A married man expecting to become a father, the prospectus states, must deposit £5 to become a policy holder. In case the policy holder's wife has twins, he will receive £50; in case she has triplets, £75. The conditions of issuing policies are simple, and are intended to appeal especially to the lower middle class, including young bookkeepers, shop clerks and small tradesmen.

\*Reported to the Clin. Soc. of Louisville, Jan. 23, 1893.

RUPTURE OF THE UTERUS FOLLOWING ADMINISTRATION OF  
ERGOT, WITH REPORT OF CASE\*

H. H. SUTHERLAND, M. D., HERRINGTON, KAN.

Early in the summer of 1888, I was requested by Mr. C—— to prescribe for his wife. He gave me the following history: Age 28 years; mother of two children, age 5 and 7 years; small; rather delicate constitution, although health previous to last confinement was good; menses irregular, profuse and quite painful, she being obliged to keep her bed several days at each period. She had heavy bearing-down pains in the pelvis, which were aggravated by standing. She suffered one to three attacks of uterine colic during each inter-menstrual period, which confined her to bed one to two days at each attack. With her menstrual trouble and uterine colic she was obliged to keep her room the greater portion of her time, being almost completely invalided.

Although I frequently urged the importance of an examination and a better knowledge of her trouble, the above history was all I could secure.

About February 1st, 1890, she conceived and soon after began vomiting, which continued until she was so reduced in strength that she was no longer able to leave her bed. After trying all known remedies without success I decided, to try cocaine, although at that time I had no knowledge of it being used in like cases. It had the desired effect and, by the judicious use of a weak solution, she was enabled to retain nourishment. In fact, the vomiting almost ceased. But a new difficulty presented itself—ptyalism in its worst form. Any attempt to arrest this would produce nausea and vomiting.

She increased in strength and was fairly well until in May, in the fifth month of pregnancy, she suddenly began flooding and came near losing her life. I was absent at the time, and Dr. N—— was called in. He gave ergot to control the hemorrhage and with partial success. The next day I found the following condition: Flooding came on very suddenly during the night, the bed clothing and mattress were saturated and the blood, passing through, formed a pool on the floor.

Patient colorless; pulse very rapid and weak; still bleeding a little; constant ptyalism and a return of the vomiting.

In her exsanguined state, and with a pregnancy of about five months, I believed it would be dangerous to tampon and wait for dilatation. Therefore, I decided at once to dilate and empty the uterus of its contents. Dr. N—— informed me that at first the os was considerably dilated, but that the ergot had caused it to contract. I found it very rigid. After considerable effort I succeeded in introducing two fingers and removed the body of the foetus, leaving behind the head and placenta. My fingers being tired, I asked Dr. N—— to relieve me. In a few minutes he removed the head and placenta, but, to our surprise, he had broken the skull, and the sharp edges of bone had cut through the anterior wall just inside the internal os, making a utero-vaginal fistula.

Our patient was in a critical condition for the next twenty-four hours; ptyalism continued for two weeks; convalescence was slow and incomplete.

In July she was able to be up and about the house. Her health was worse than before the pregnancy. Assisted by Dr. N—— I closed the utero-vaginal fistula and also repaired an old bilateral laceration of the cervix which had occurred during a labor five years previous. Improvement was marked from that time.

At present her health is completely restored, and for more than eighteen months she has done all of her housework—including the washing. Her menses are normal and the attacks of uterine colic have practically ceased. To use her own expression, "life is now worth living."

While there are some who condemn operations on the lacerated cervix, I believe it has done as much to relieve suffering as any other one operation on the female pelvic organs. Had I been permitted to learn the true condition of the cervix and to have repaired the injury, I am confident my patient would have been spared all her trouble, both before and after conception, and would have gone to full term.

\*Proceedings of the Western Association of Obstetricians and Gynecologists.

There are a few points of interest:

(1.) The persistent vomiting, controlled by cocaine and followed by ptalism, which continued for some time after abortion.

(2.) The use of ergot to control hemorrhage, instead of emptying the uterus of its contents.

(3.) The dangers which may result from the indiscrete use of ergot.

(4.) The danger in crushing the skull in order to remove it.

(5.) The restoration of health; the cessation of uterine colic and menstrual trouble by repairing the previously existing lacerated cervix.

## SOCIETY REPORTS.

### THE CLINICAL SOCIETY OF LOUISVILLE.

*Stated Meeting, February 21st, 1893.*

DR. J. M. KRIM, Vice President, in the Chair.

#### CARCINOMA OF THE MAMMÆ.

DR. W. O. ROBERTS: The patient from whom this specimen was removed is sixty-seven years of age. Four years ago she had a growth that came on the end of her tongue, which she said when first noticed was as large as a pin's head; it steadily increased in size. One year after its appearance it was removed and was then about the size of the first joint of her little finger. It bled very freely at times. Since its removal there has never been any appearance of the trouble about the tongue.

The growth which I have here was first noticed in the breast last fall a year ago; it was then about as large as an almond; it has steadily increased in size up to the present time, and there is marked retraction of the nipple. Her father died of cancer and two of her sisters have had operations performed for cancer. This tumor occurred without any history of injury whatever. She had, however, in earlier life some trouble with this same breast during the nursing of her children. I do not know how many children she has had, but with each of them she said she had more or less trouble with this breast, but never had an abscess. This case is very much like several others which I have had recently, where there have been several cases in a family of malignant disease.

The breast was entirely removed, of course down to the pectoral muscle; the

fascia was carefully dissected up and the axilla thoroughly cleansed.

Last summer, just before the Congress of American Physicians and Surgeons, Dr. John Chiene, of Edinburgh, stopped over in Louisville, on his way to attend the Washington meeting, and he had with him an article from his assistant, Mr. H. J. Stiles, of Edinburgh, concerning the method of determining whether or not all the malignant growth has been removed in an operation for cancer of the breast. I thought possibly it would be of interest to the members of this Society if I would read an account of Mr. Stiles' method. The extract I have here is taken from the "American Text Book of Surgery."

"Mr. H. J. Stiles, of Edinburgh, has recently devised a method for detecting carcinomatous tissue, so that the surgeon at the time of the operation can ascertain whether he has removed all the carcinomatous tissue, or whether some portion still remains in the wound and should be removed. His method is as follows:

(1), Mark the position of the heart by a slight incision extending both on breast and on the skin which is to be left. This is to enable the operator to identify the position, and therefore, the corresponding surfaces of the breast and the wound after the removal of the breast.

(2), Wash the breast in water to remove all traces of blood. This is important, because, after treatment with nitric acid the blood becomes blackened and difficult to remove, and therefore, greatly obscures the appearance which the acid brings out.

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(3), Submerge the whole organ in a 5 per cent. aqueous solution of nitric acid, (B. P.) for about ten minutes, that is to say during the time the surgeon is cleaning out the axilla.

(4), Wash in plenty of running water for five minutes.

(5), Place in methylated spirit (undiluted) for two or three minutes.

(6), Examine the whole surface very carefully to ascertain (a), whether any part of the tumor is exposed on the surface, or (b), whether any locally disseminated cancer foci are exposed on the cut surface, or (c) whether breast tissue is exposed.

The effect of the above given method is to render all carcinomatous tissue and parenchyma dull and opaque white through coagulations of the albumen of the protoplasm of the cancer and epithelial cells. The fibrous tissue of the stroma is rendered gelatinous, translucent and homogeneous in appearance and somewhat India-rubber-like in consistence. The fat is unaltered. If any dull opaque spots of carcinoma appear on the under surface of the breast, more tissue must be removed at the corresponding point in the wound. This point is easily determined if the breast has been marked as directed. After examining the surface of the organ it should be cut in thick slices which are to be treated in the same way; thus the various normal and pathological constituents of the mamma can be readily and most satisfactorily studied. Cancer and parenchyma can be at once detected, if present, upon the cut surface and since the examination can be easily completed before the time for suturing the wound, this method affords the surgeon a valuable aid in ascertaining the limits of the disease, and of the organ.

#### DISCUSSION.

DR. A. M. VANCE: I would like to ask Dr. Roberts if he tried the method of detecting cancerous tissue in the case reported by him.

DR. W. O. ROBERTS: I did not have an opportunity of trying it in this case. Mr. Chiene told me that his assistant was now using it in all his operations, and has great faith in it. I have a great deal of faith in Mr. Chiene and the first opportunity I have, shall try the method.

DR. WM. BAILEY: I do not know that such a thing would be possible, but it oc-

curs to me if some method could be devised whereby an observation or test could be made of the surface left after removal of the tumor to determine whether any cancerous structure remained—if this could be done in some way without injury to the patient—I think it would be a better thing.

DR. T. P. SATTERWHITE: I believe the general rule, whether malignant or not, is to give full scope to all tumors, especially if the growth be of a suspicious character, an abundance of healthy tissue being taken away.

I remember a lady who, a few years ago, had a tumor about the size of a hickory nut in the breast, that gave her some discomfort and a little pain. I do not think her attention was called to it longer than a month before I removed it. I took the specimen to an eminent pathologist in the city, and asked him to make an examination and give me a positive opinion as to its character. He would not give me a positive opinion and I took it to a second pathologist who pronounced it carcinoma without any hesitancy, stating that it not only was cancer, but was an exceedingly malignant form. In removing that tumor I took out a quantity of healthy tissue, removing everything down to the muscle. The wound had no sooner healed than the growth returned; it was again removed, the tumor being no larger than a filbert; in a short time it returned again, showing that the last physician's opinion was correct.

I had a talk with Prudden, of New York, who is considered one of the best and most reliable microscopists in the country, with a view of testing as to whether or not all of the diseased or malignant structure had been removed at the time of operation, and he told me there was no possible way it could be done; that you might have a microscope there while operation was going on, to put a portion of the edges under observation, and yet it was an utter impossibility to tell. So I do not know how surgeons are to determine positively when they have removed all the diseased structure unless the method mentioned by Dr. Roberts is a reliable way.

DR. WM. BAILEY: I can conceive how the work would be very difficult, because the cells cannot always be recognized under the microscope. It is only by the

arrangement of cells that carcinoma can be detected, and this may not be easily determined in all cases.

I rose to mention a case: Three or four years ago a woman, between forty-five and fifty years of age, came under my observation with a tumor in the breast that gave her some concern, some pain; tumor not much larger than the end of my thumb; it remained there with but very little growth for a year's time; in the meantime the woman became the subject of cancer of the rectum and died from it without further development of the cancer (which I believe it was) of the breast. The development of the growth in the breast was so slow and gave her so little concern that no operation was ever performed for its removal. The fact that the patient died of cancer of the rectum is confirmatory evidence that my diagnosis of cancer of the breast was correct.

DR. J. M. KRIM: I simply wish to mention the case of a woman who has been operated upon three times for cancer, and is still in existence. The first operation was twenty-three years ago when the left breast was removed; about two years afterward the right breast was removed, and I think it was a year later when the growth returned on the left side just below where the breast was excised; this time the tumor was allowed to reach about the size of an orange when it was carefully removed, and she has had no trouble since. Dr. Bayless, at the time, pronounced the structure malignant and evidently it must have been; however, it has been fifteen years since the last growth was removed and there is no evidence of a recurrence now.

DR. W. O. ROBERTS: I have very little to say in closing. The only way is to continue to remove tissue until you fail to find evidence of carcinomatous structure. It strikes me that the method I have referred to is about as good as any. Of course it requires a man with some experience to carry on an examination during the time the operation is being performed, one, however, much less expert than would be required to use the microscope with frozen specimens. We endeavor, of course, in all cases to cut well beyond the diseased structures. There are some operators who make what is called a "cart-wheel incision," endeavoring to remove all diseased structures with-

out any view whatever of approximating the surface afterward. There are some who remove all the tissues over the breast, go down and remove the greater part of the pectoral muscle, and then bring a flap up from behind to cover the breast—that is Halstead's method of operating. I think in all cases we should remove all suspicious tissue, and especially clean out the axilla—I believe this is of the most importance.

Dr. Wm. Cheatham presented "Paralysis of the Laryngeal Muscles, with Cases" as the subject for the regular essay. (See page 486).

#### DISCUSSION.

DR. WM. BAILEY: One point—that is whether or not obstructions or difficulties of the larynx are not characterized by inspiratory dyspnoea instead of expiratory? I believe it is a fact that as a rule, as you go into a room where a patient is suffering with dyspnoea, you can locate the site of the trouble by observation of the dyspnoea. It is particularly characteristic that there is inspiratory trouble at the larynx, and expiratory trouble with other portions of the passage. We all know that a characteristic of emphysema is trouble in getting air out of the lung, difficulty in expiration. This is also true in obstructed respiration from other causes—if only one act is difficult, respiration is always slower than natural; if both acts are difficult then respiration is hurried. But if the obstruction is at the entrance of the larynx, or if it be emphysema, nature in a conservative manner prolongs the difficult act.

DR. W. O. ROBERTS: I would like to ask Dr. Cheatham whether or not this tube his patient is wearing interferes with deglutition?

DR. CHEATHAM: No, except for fluids.

#### SPASMODIC STRICTURE OF THE ŒSOPHAGUS.

DR. A. M. VANCE: I want to mention a case I saw once that has always puzzled me. I was called by Dr. Clements one night to see a little child three years old, that could not swallow. I introduced a stomach tube and put some milk into the child's stomach. I suggested that a trial be made with cocaine spray in the throat and soon discovered that the child

could swallow perfectly just after the cocaine was used. For a number of days each time the throat was sprayed with cocaine, the child could swallow with comparative ease. It soon irritated the throat so that it became sore. The child afterward died of pneumonia. I have often wondered whether there was some form of paralysis preventing the child from swallowing, or whether there was some neurotic condition which the cocaine relieved temporarily.

## DISCUSSION.

DR. CHEATHAM: I have no doubt the case reported by Dr. Vance was spasmodic stricture, which was relieved by the cocaine.

Referring to Dr. Bailey's remarks: I have seen several cases of this kind where the trouble was in expiration, though, possibly as a rule the difficulty is in inspiration.

## CASE OF BRAIN SYPHILIS.

DR. W. O. ROBERTS: I have a patient who is now forty-eight years of age. Twenty-five years ago he contracted syphilis. I saw him during the tertiary period of the disease, and he had very large and very extensive ulcerations of the soft structures of the extremities. I remember distinctly, one upon the elbow joint which involved the tendon of the triceps muscle. He had very large nodes on both tibia. He was under treatment with iodide of potassium, also some mercury for something over a year, and all the symptoms disappeared. He went to a distant city and remained for several years—probably a period of ten years. He returned suffering from asthma; it was so bad that he had great difficulty in breathing—could not go up steps or take any exertion without getting entirely out of breath. Under iodide of potassium these symptoms entirely disappeared. There was no valvular disease of the heart; no evidence of urinary or kidney disease. He suffered at the time he had asthma, from indigestion and he still complains of that trouble. A year ago he had most terrific headaches, and I thought at the time that they were possibly due to grippe. He was treated for that without benefit. Finally I put him on iodide of potassium which gave entire relief. After quitting the iodide for a period of six months, a node appeared on the forehead about as

large as the first joint of my thumb. He was put back on iodide and this passed away and left a depression which can be easily seen at some little distance. He has had no headache for some time. A day or two after eating a hearty dinner, without any especial dyspeptic symptoms following at the time, he was taken with a well-marked attack of epilepsy, coming on by the jerking of one hand, finally shaking all over, then becoming unconscious, biting his tongue, frothing at the mouth and all the symptoms of well-marked epilepsy.

Upon inquiry I found that years ago while out West, he had a number of dizzy spells, but at no time lost consciousness, and within the last year he has had a number of these attacks, taking them to be simply vertigo from indigestion.

The question I want to ask is whether or not this epileptic attack is the result of brain syphilis; whether epilepsy occurs in a person of that age, except as a result of injury or structural disease of the brain.

## DISCUSSION.

DR. W. P. SATTERWHITE: I should infer from his having had these severe symptoms of tertiary syphilis, that the present trouble is due to that cause.

DR. WM. BAILEY: There are several very interesting things in this connection, and I want to say this much in regard to the asthmatic attack—the relief by iodide of potassium of the asthma does not prove the syphilitic origin of the case, because iodide of potassium is the best known treatment for asthma. It will relieve more cases than almost anything else. I do not believe as a rule epilepsy occurs in a person of this age, but this man may have been subject of *petit mal* without knowing what it was.

I remember seeing a case with which Dr. Roberts is familiar, which I will mention in this connection: One evening after having eaten an enormous dinner, a man over fifty years of age had two attacks that were very much like epilepsy. He had no recurrence, and I thought the safety to him was by virtue of his age, and that perhaps it was brought on by disturbed circulation from over eating; he had been in bad health for months and had not at that time very fully recovered. This case goes to confirm my opinion that it is still very doubtful about the cure of syphilis. How are we to know when a



man is cured of this disease; when a man has gone practically for years and years without any new history, comes out again with decided manifestations of syphilis. We have by means of treatment with mercury and iodide of potassium brought it into subjection, so that for many years it may not manifest itself, but I have seen so many cases where after ten, fifteen and

twenty years, symptoms develop again, that I have a little doubt whether we can be very sure about the absolute cure. I think I saw two sisters die neither of whom had any symptoms of syphilis for thirty years; both died apparently of brain syphilis. This disease is very difficult to eradicate, and we never know whether it has been done or not.

## WESTERN ASSOCIATION OF OBSTETRICIANS AND GYNECOLOGISTS.

*Annual Meeting: Kansas City, Missouri, December 27th, 1892.*

### [OFFICIAL REPORT]

Dr. Van Eman's paper. (See page 408.)

#### DISCUSSION.

DR. SHELDON: It seems to me, Mr. President, that the mere point of location of fecundation is not sufficient explanation for an adherent placenta. Whether it was at or near the mouth of the Fallopian tubes, or whether it was further within the body of the uterus, had there been no other factor, I think it would not have been sufficient to have produced the adherent condition. I take it that the class of adherent placentas to which the doctor has referred, is usually, if not always, caused by inflammation that has existed either as endometritis or as placentitis. One or both of those conditions must have taken place. This woman felt a pain in that locality during the whole of pregnancy. I think that is often, if not always, the case. There has been a low, sub-acute or chronic condition of inflammation, and new tissue has been formed connecting the placenta and the wall of the uterus. It has gone even further than that, and in some cases, where there has been extensive adhesions of the placenta, the muscular fibres have been often reproduced, extending from the muscular fibres of the womb into the placenta. As a rule, the new tissue is connective tissue, but we get another condition sometimes where the myoblasts or the fixed cells of muscles are reproduced, or reproduce themselves, until we get a muscular tissue extending from the wall of the uterus to the placenta.

Of course, we have many other causes for retained placenta, but I know of no other causes of adherent placenta, and the

paper, it seems to me, should have been entitled, "Unusual Cause For Adherent Placenta," and not for retained placenta.

We may have retained placenta from irregular contraction. The circular fibres of the womb near the internal os or further up, make what is often called a "hour-glass" contraction. You may find it sometimes as the result of giving large doses of ergot. But we do not have an adherent placenta unless we have a formation of new tissue as the result of inflammatory action. I take it that the process which we call inflammation, in this condition as well as any other part of the body, is a physiological condition, and that it is an effort of Nature to repair a certain injury that has been done either to the placenta or to the endometrium, or to the walls of the uterus itself. There has been some injury done, either by some toxic germ or some traumatism, perhaps, or from some other cause, and Nature, in an effort to repair that injury, has formed new tissue and the new tissue forms the adherent condition that we find in these cases of retained placenta.

DR. LANGWORTHY: It seems to me that the gentleman in discussing the paper just read, and in giving the theory of inflammatory action as explaining the cause of retained placenta, has lost sight of the fact that the writer stated in his paper that this placenta was contained largely in the widely distended Fallopian tube. Now then, the gradual distension of this tube by the growth of the placenta would fully account for the pain which the patient experienced, leaving out any acute or sub-acute inflammation. It seems to me that a point in the paper has

been lost sight of, and that is, that it accounts for this retention by the hypothesis that the fixation took place in the tube instead of in the uterus in the usual manner; and the whole argument hinges upon the one theory that fixation takes place at the moment of fecundation. I once heard a scientist in discussing the theory of evolution, say he would like very much to believe that theory because it so nicely explained a great many things; but, unfortunately, there were some reasons why he could not believe it. Now whether there are any reasons why we cannot believe that fixation takes place at the moment of fecundation, I am not prepared to say; but the doctor, by this theory that fixation takes place at the moment of fecundation, very nicely explains the phenomena of abdominal pregnancy and, in the case of tubal pregnancy, that the placenta is adherent in the Fallopian tubes and various other phenomena in connection with this. I merely call attention to that point.

DR. SHREVE: I think Dr. Van Eman and Dr. Sheldon are both correct in that it is not doubted that attachments are caused by inflammatory action. The simple fact that the conception took place in the uterine end of the Fallopian tube, and the distention of that tube being gradual, would of itself create an inflammatory action sufficient to cause adhesion. I believe that Dr. Van Eman is correct, that there is the spot where the ovum and spermatozoa came in contact and that there the attachment is first formed. In the past five years I have had two cases similar except, that in one of them there was an hour-glass contraction with an attachment in a funnel-shape pouch at the uterine end of the Fallopian tube. I could pass my finger very readily into the tube and it was a perfect funnel-shape, and there was where the attachment was in both cases. One was simply a retention with a very slight attachment at that point, and in the other there was extensive adhesion coupled with an hour-glass contraction. At the removal of each placenta I was extremely careful to examine the opposite cornus of the uterus, and I found everything in a normal condition, but the complete funnel-shaped pouch in the right side of each case.

DR. LANPHEAR: As a student of pa-

thology, and not as an obstetrician, I beg to call attention to the fact that inflammation does not occur from simple irritation, from the presence of a fetus, or any other body. Inflammation is of itself infective in origin. There cannot be inflammation without an infective process going on. That is a fundamental principle of modern surgical pathology. Therefore the mere presence of the fetus in the Fallopian tube does not inflame and cannot excite inflammation. Where apparent inflammatory processes are present it is where rupture has occurred and where nature has attempted a reparative process, but in that process of repair, inflammation does not take any part unless there is infection from some outside source.

DR. SHELDON: Allow me to ask what you mean by infection—that you can't have inflammation without infection?

DR. LANPHEAR: I mean to say this, that inflammation never comes from simple irritation; that is, there must be infection from gonorrhoea, from sepsis, from something outside, or possibly, from the presence of destructive pus from the inside; but there is no such a thing as inflammation arising simply from the presence of the fetus, or anything else that is not implicated with the infective material, septic or otherwise.

DR. SHELDON: It seems to me that I am not ready yet to accept the theory advanced by Dr. Lanphear, that we cannot have inflammation without infection. If I understand pathology correctly, the condition that we call inflammation and the condition that we denominate repair of tissue are identical.

I take the position that, so far as we know, there was no infection in this case, but there was a condition of repair and formation of new tissue. I take this to be a pathological fact that each tissue reproduces itself and nothing else—reproduces itself or a similar substance histologically. Now, as I said before and as the doctor found here, there was new connective tissue that had formed between the endometrium and the placenta and that, of course, extended up into the tube; it matters not where it was, but that was the condition that he found. And this new tissue had been developed from connective tissue cells, but there is no indication that there had

been any infection there. Take, if you please, a simple incised wound or a simple contused wound, and perhaps that is what the doctor had here. He might have had traumatism; we don't know. But there was something that had injured the tissues there, and nature had set up an effort to repair that injury. We get the same thing when we have a wound; we get an increased hyperemic condition; we have more or less swelling of the parts; we have effusion of the leucocytes and blood serum in the tissues that are to be repaired. Nature makes all this effort, and in this effort new tissue is produced from the existing fixed cells. Now, in subcutaneous incised and contused wounds we don't have any infection that we know of. I don't think it can be proven that we have, but we have a condition that we call inflammation, or a condition which I and others are pleased to call, a condition of repair. That noted surgeon of Philadelphia, Dr. Roberts, says that inflammation is a physiological condition, that it is an effort of nature to repair injured tissue. Those are not his words exactly but those are his sentiments. Senn says, in his work on surgical bacteriology, that inflammation is a physiological process, an effort that nature makes to repair injured tissue, etc. Almost identically the same words are used by those two authors; and nowhere, can I find a statement that it is necessary to have infection by some germ, or whatever it may be, in order to have inflammation.

DR. VAN EMAN: The first objection that I hear, is that the title of the paper should read "adherent" and not "retained." I haven't any objection whatever to changing the title.

Now as to the cause; possibly there was inflammation there; possibly, on the other hand, nature found something was wrong and undertook to wall the thing in. That is theoretical.

The woman was delivered, and inside of twenty-four hours, in spite of every cleanliness, she has developed every evidence of septicæmia; there is constitutional disturbance and everything else. It may be she was infected by the doctor, and it may be she had infected material in the Fallopian tube for which the doctor was not responsible at all. If a man falls down in going home and gives his ankle a violent wrench

and goes to bed and, if he goes to sleep at all, wakes up in the morning with it swollen the size of two or three ankles, there is certainly inflammation there, but whether it is from germs or not I don't know. Now when this placenta was retained, it hadn't anything whatever to do with inflammation. There was nothing in the paper about inflammation; I have not been discussing the question of inflammation and I do not propose to discuss it now. But I wish to say that during the second stage of labor, the voluntary muscles aided very little in the expulsion of the fœtus, that is in bringing it down into the vagina—and that was very largely caused from this placental adhesion acting as a splint to one side of the uterus, preventing the contractions and making them irregular. Now had this been simply an adherent placenta without any abnormal location of any portion of it, those contractions were certainly firm enough to have pulled it loose from the uterine wall, as is done in every case of delivery, whether it be normal or abnormal. It didn't do it simply because a large portion of the placenta laid out in the funnel shaped extremity of this tube, and the uterine walls were dilated by it and hadn't any power to contract and express. It was just simply held up there as if it had been tied, or occluded or set in there. Had this woman been so unfortunate as to have fixation of the ovum take place further out, we would have had the same funnel-shaped dilation of the tube but different results. Now it was simply funnel-shape here, but had no contractile power; even if the uterus did contract on it, it simply shut down. The moment I got my two fingers in there and worked around and detached it, my hand and the placenta were promptly expelled. It doesn't make any difference so far as this paper is concerned, whether the woman had inflammation or not.

As to the history of the case; I didn't wait upon her in her two previous labors, but I had known her more or less since her marriage. She came under my observation about the fourth month of her pregnancy; she had been to half a dozen doctors and some said she was pregnant and some said she was not. I decided she was and the results proved it. In five months more I delivered her—assisted in delivering her rather.

Now the reason why this placenta was



retained; it was simply grasped as you grasp a hand, and if it had not been that those contractions were exceedingly powerful—she was a very strong woman—if it had not been for those powerful contractions it would have been expelled very promptly. There is no resemblance between this case and the hour-glass contraction, except that possibly you might have an hour-glass contraction following. All I have to say is that in the hour-glass contraction, twenty-five years ago when I studied medicine I was instructed to give ergot; I wasn't even told not to give it. In primiparæ I was to give ergot; if I got tired, instead of putting on the forceps, I was to give ergot. And I want to say right here that the man that calls himself a doctor and has so little judgment that he would put on the forceps to get away, or put on the forceps in the condition described by Dr. Price, isn't fit to look inside of a lying-in room, much less to take charge of a patient. After awhile I found that ergot wasn't to be given indiscriminately; and I had more hour-glass contractions when I gave ergot than I have since without giving ergot. But the man who gives ergot without reference to the stage of labor because somebody else gives ergot, and doesn't make any use of his brains, will have plenty of hour-glass contractions and plenty of retained placenta, whether they are adherent or not.

#### Pregnancy and Ovarian Tumor.

Dr. Wm. Gardner (*Montreal Medical Journal*) says:

The association of pregnancy and ovarian tumor, if left to nature, is fraught with danger to the woman, whether the termination be premature, or at full term. When left to nature, abortion or premature labor may occur, in either case with frequently fatal results to the mother.

When the case proceeds to labor at full term, the result to the mother may be rupture or such other injury to the tumor that fatal peritonitis carries her off.

Tapping of the tumor, while it may temporarily relieve tension, is by no means free from danger by injury to the uterus, or otherwise, and it does not cure the patient.

Ovariectomy with modern precautions is nearly as safe as in the non-gravid condition of the uterus, while the woman is at

once cured of a disease which must ultimately demand operation.

The second case here related shows that serious complications such as torsion of the pedicle and consequent peritonitis with adhesions, necessitating the use of the drainage tube for so long a period as five days, does not necessarily lead to abortion.

Ovariectomy in the present status of surgery, in the great majority of cases, must be the only proper treatment, and is often urgently demanded to relieve tension.

The indication for the operation in the case of small abdominal tumors is even more urgent, because of their great liability to torsion of the pedicle; and in the case of the pelvic tumors, by reason of the almost certain rupture or necrosis from compression during labor.

Mark Twain, says an exchange, was at one time director of an accident insurance company, and being called upon at an entertainment in London to make a speech, introduced the following allusions in his remarks: "Certainly there is no nobler field for human effort than the insurance line of business—especially accident insurance. Ever since I have been a director in an accident insurance company I have felt that I am a better man. Life has seemed more precious. Accidents have assumed a kinder aspect. Distressing special providences have lost half their horror. I look upon a cripple now with affectionate interest—as an advertisement. I do not seem to care for poetry any more. I do not care for politics—even agriculture does not excite me. But to me, now, there is a charm about a railway collision that is unspeakable.

There is nothing more beneficent than accident insurance. I have seen an entire family lifted out of poverty and into affluence by a simple boon of a broken leg. I have had people come to me on crutches, with tears in their eyes, to bless this beneficent institution. In all my experience in life, I have seen nothing so seraphic as the look that comes into a freshly mutilated man's face when he feels in his vest pocket with his remaining hand and finds his accident ticket all right. And I have seen nothing so sad as the look that came into another splintered customer's face when he couldn't collect on a wooden leg.

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SATURDAY, APRIL 1ST, 1893.

## EDITORIAL.

### ANÆSTHESIA.

The New York daily papers, of the 26th of March, contained a statement over the names of the attending surgeons, and made, it is said at the request of the family and friends of Col. Elliot F. Shepard, concerning the death of the latter under ether. The statement is substantially as follows: On Friday afternoon, March 24th, ether was administered to Mr. Shepard with a view of exploring the bladder for stone and, if practicable, removal of the calculus. The statement is that ether was begun at 12.45 P. M. and that for a few moments he inhaled "uncommonly well, his breathing being full and free." Afterwards (time not stated) "his color changed somewhat and it was apparent that he was nauseated. In another moment he vomited. After this his color was better, but as his respirations were not satisfactory, nor his pulse, the further administration of the anæsthetic was discontinued. As yet not enough ether had been given to admit of proceeding with the proposed operation." . . . . "The

breathing continuing very labored, an examination was made of the larynx to determine whether possibly some article of food had lodged in it, but such proved not to be the case."

"The patient's condition was now so alarming as to call for extreme measures, and in hope that the symptoms might be due to the presence in the wind-pipe of vomited material accidentally inhaled, the operation of tracheotomy . . . . was performed. No foreign material of any kind was found and we even passed a rubber tube down the wind-pipe and into the bronchial tubes, making use of a powerful aspirating syringe without discovering the presence of anything but bloody mucous."

Oxygen was used "and under its influence the patient slightly revived." "Artificial respiration, and every other means which might possibly give relief, was resorted to." "From this time on his breathing became even more embarrassed, but still artificial respiration was contin-

nously kept up although the pulse became steadily more feeble."

"He sank rapidly into unconsciousness, and, in spite of all efforts, died at ten minutes after 4 o'clock. In our opinion Col. Shepard died of sudden œdema and congestion of the lungs following the administration of ether, but, primarily, due to some cause unknown to us."

(Signed) JAMES W. MCLANE,

CHAS. MCBURNEY, M. D.

This statement, while prepared for the public press and not for the profession probably covers the matter sufficiently to justify comment. The names attached to the statement are sufficient guarantee of the skill and ability that would be applied to avert such a calamity by every known means that could be made available. The statement gives the impression that death was due to ether, certainly as the exciting cause. Can this death be justly ascribed to ether? The diagnosis of œdema of the lungs was made apparently on physical examination alone; no *post-mortem* was made and, in the absence of any technical description of the case, we are left in doubt as to the true cause of death.

It would certainly be most extraordinary for œdema or congestion of such proportions and rapid fatality, to result from the inhalation of ether given over so short a period of time that the patient was not sufficiently anesthetized to permit of starting the operation. Bronchorrhœa is an ordinary complication, but in such proportions as to prove fatal as in this case is unheard of. To us it would seem more probable that an apoplexy had taken place in the brain. And before charging the death to the account of ether, it would be well to know just how the ether was administered.

This unfortunate occurrence serves to strongly emphasize the fact that anesthesia is *never without danger*.

Mountains of words have recently

been piled up concerning anesthetics and their physiological actions. The researches and the discussions of the Hyderabad Commission have been published throughout the world, and the ultimate result appears to be an irreconcilable conflict as to whether chloroform kills by paralyzing the heart or the respiratory centers first. Ether as an anæsthetic was practically ignored.

But the every day practitioner does not care so much to learn how to kill his patients by anesthetics, as he does glow to extend to them the blessings of necessary unconsciousness with the greatest security to their lives and welfare. The ideal anæsthetic—that which will suspend all functions but life itself; that, without any disagreeable coincidences or consequences, will allow the patient to come out from its influence in a better condition than before going under; that no organic disease of brain, heart, kidney or lungs will offer contra-indication to its use; that will act instantaneously and alike in all classes and conditions—the ideal anæsthetic has not yet been discovered, and probably never will be until time has passed into the millenium.

In the meanwhile, it behooves us to use the agents at our command with discretion and pains-taking care. Experience both as an anesthetizer and as an operator has lead to the following general conclusions: Everything taken into consideration, ether is the desirable anæsthetic for use in general work. The principal objection urged against it, *i. e.*, its irritant action upon the kidney and consequent contra-indication where kidney disease exists, is much more apparent than real. Certainly we would prefer to take the risk of the effects of ether on the kidney rather than to take the chances of using chloroform with its attendant and multiform dangers.

The successful use of ether depends on the anesthetizer and the quality of the ether used. Possibly many of the



lives that have been lost under chloroform, and probably most of those lost under ether, might have been saved had the fact being recognized that the anæsthetizer is a factor of importance not inferior to the operator himself. If it were more generally realized that it is the *anæsthetizer* who, in ninety-nine cases out of a hundred, holds the life of the patient absolutely in his hands, and that with *him* rests the present issue of life or death, the custom of entrusting this duty to the hands of the least experienced and youngest man available would be relegated to the limbo of the relief of barbarism, and the mortality lists of operators would show a marked decrease in death from "shock." It is not often the operator loses a case "*on the table*." Not infrequently does he lose his patient from "surgical shock," which might well be called "*drowning by anæsthetics*."

The anæsthetizer must be pre-eminently a man of common sense. He should appreciate his responsibility, and if he does this he will know, see or hear nothing but the condition of the patient whose life ebbs or flows at his will. He has absolutely no business to know what is taking place apart from his own duties. He must possess confidence in himself, and be able to inspire his patient. Almost always he can gain a control over the will of the patient that will very materially aid in the successful performance of his office. His responsibility begins with his first introduction to the patient and does not end until the patient has safely recovered consciousness.

Of importance also is the *quality* of the drug used. Experience has shown that ether kept for a long time in a drug store, exposed to light or not hermetically sealed, will deteriorate. If it is not deterioration it is adulteration. Sulphuric ether, thoroughly washed and put up in sealed cans, is said to keep indefinitely. One accustomed to the use of ether can

readily detect by the effect upon himself and the rapidity of evaporation, whether the drug is effective or not. Sulphuric ether unless thoroughly washed is potent for producing the distressing after effects of ether sickness.

The *quantity* of the drug used is immaterial. It is the effect upon the patient that is essential.

Patients who suffer from bronchorrhea are most apt to have the after sickness. Alcoholics are less susceptible to the effects of ether and more difficult to manage than are those free from the influence of alcohol. Ether acts more quickly and produces less ether sickness in patients who have nothing in the stomach, and whose bowel has been thoroughly emptied previous to receiving the anæsthetic. Abstinence from food or drink for twenty-four or more hours after anæsthesia will prevent much of the after sickness. Where retching is uncontrollable the use of small quantities of hot water to afford the stomach something to dispose of, will generally stop the distressing condition.

Strychnia administered hypodermatically is the best and safest stimulant where profound depression requires its use.

Of the greatest importance, and the end to be unceasingly sought for by every administrator of anæsthetics, is that condition, the golden mean between consciousness on the one hand and coma on the other. No one indication holds good for all cases. Muscular reflexes are snares for the unwary. The sensitiveness of the conjunctiva is absolutely valueless. An experienced anæsthetizer can often estimate the degree of unconsciousness by the reactions of the pupils to light. But it is not at all a safe criterion.

But there is one indication that applies to the vast majority of patients under anæsthesia, and is the most reliable of all signs for estimating the degree

of the condition: If a patient has passed into the third stage of anaesthesia—the stage of the abolition of all voluntary muscular effort, the reflexes inhibited and complete relaxation obtaining—now, if the ether be withdrawn for a short time and then readministered, the patient will show the signs of irritation in the throat by the *motions of swallowing* and, if the ether has been withdrawn too long, by choking. This point, *where the addition of a little fresh ether will cause these efforts at swallowing*, is the landmark by which to gauge the depth of anaesthesia.

It is the line where the second merges into the third stage of unconsciousness. Sensation is abolished, muscular relaxation is established and all the senses are held in abeyance. The complete withdrawal of ether will allow speedy reaction; the addition of fresh ether will deepen the unconsciousness. A safe rule, therefore, is to try the effects of a little fresh ether frequently, *and if it produces no signs of irritation in the throat, withdraw it*. The anaesthesia is sufficient. If, however, fresh ether *produces the evidences of irritation, continue the administration until fresh ether will not cause the signs*. If this is not done the patient will continue to regain consciousness, with the undesirable effects of muscular resistance, etc.

Never forget that many patients will pass through the first and second stages with considerable resistance and excitement, and, reaching the third stage, will plunge into a coma so profound as to excite alarm.

Anaesthesia should always be administered with due regard to personal idiosyncracies of the patient. Always with gentleness and encouragement to the patient; never rudely or suddenly. The mental impression has much to do with the ultimate results.

In certain major operations, for instance

an hysterectomy, where the removal of a member entails profound shock, the shock may be very much lessened by deepening the coma at the instant of removal.

Simplicity in every detail; exclusive devotion to his duty on the part of the etherizer; a constant realization that his actual responsibility is equal if not superior to that of his principal, and the guidance of all action by hard common sense are elements necessary to qualify one for success as an anaesthetizer. Unfortunately comparatively few physicians are capable of safely administering an anaesthetic, and this, too, without any excuse whatsoever.

As medical men realize the vital responsibility attaching to this office and adjust themselves accordingly, the number of deaths alleged to be due to anaesthetics including the treacherous chloroform, will very markedly diminish, and those deaths from the water-logging of the system *yclept shock* will exist only in the records of the past.

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\*Dr. V. R. Hacker reports that in the clinic of Billroth during the last ten years there were treated in all 41,366 patients. Among these were 270 suffering from diseases of the oesophagus. Of these, 131 cases (114 males, 17 females) from carcinoma, 47 cases of stricture due to cauterants, chiefly lye (18 males and 29 females.) The results of the cases of cauterization were as follows: One-third at least died from the direct poisonous results of cauterants taken with suicidal intent. Those cases following the use of lye one-fourth proved fatal, and more than one-half died from sulphuric acid poisoning. Those who recovered from the first effects of the lye poisoning more than 50 per cent. suffered from grave stricture, the remainder having milder forms of stricture. More than one-third of those who survived the sulphuric acid poisoning suffered from grave strictures.

—*Schmidt's Jahrbucher*, Bd. 237, No. 1.

\*Translated for THE MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

## TRANSLATIONS.

## AN OPERATIVE PROCEDURE APPLICABLE TO LARGE PUS TUBES CLOSELY ADHERENT TO THE UTERUS.†

Chaput (*Jour. de Méd. de Paris*, Jan. 15, 1893) remarks that the treatment of pelvic suppuration remains the order of the day. Some, including Péan and Segond, persist in performing vaginal hysterectomy in preference to laparotomy for all cases of bilateral suppuration; others, represented by Pozzi, le Denter, Terrillon, Championnière, Terrier, etc., claim that hysterectomy should only exceptionally be performed, reserving all their sympathies for laparotomy. Chaput classes himself with the latter writers, and only undertakes hysterectomy when he recognizes, after opening the abdomen, that ablation by the other method is absolutely impossible. He also prefers hysterectomy when there are purulent fistulæ opening into the bladder, vagina or rectum. He regards hysterectomy as an operation full of dangers and disagreeable surprises; patients are often lost by hemorrhages and, moreover, septicæmia is the principal cause of death, and it appears more frequently than in laparotomy. Hysterectomy also exposes the small intestines, the pelvic colon, the rectum and, at times, the cecum to the danger of being wounded; the uterus, and especially the bladder, are often perforated. Finally vaginal hysterectomy leaves in the abdomen the entire sacs, open or intact, and it must be remembered that the subsequent treatment of this operation is difficult and delicate. Without much danger of septicæmia, laparotomy does not expose the viscera to the danger of wounds; it usually permits of complete ablation of the disease and the after-treatment is particularly simple.

Chaput calls attention to a serious complication in which the tubes adhere strongly to the uterus, and cannot be separated without the risk of a hemorrhage very difficult to control. In a case of this kind he follows a technique which he deems of sufficient interest to report in detail. The history of a case of this class is as follows: A woman, 38 years old, menstruated at sixteen normally.

At 23, she was delivered of a child without any attendant complications. She nursed her child for one year although the menses returned normally at the end of three months. At 26, she had a miscarriage from which she appeared to recover rapidly and completely. There were no clear proofs of gonorrhœa. She commenced to suffer from uterine disease in July, 1892; at that time she was seized with violent pains in the right iliac fossa, propagated to the thigh. From this time she suffered constantly in the abdomen and thighs; her menses lasted fifteen days and were abundant and painful. During the fifteen days that followed there existed a very abundant leucorrhœa. On her entrance into the hospital on September 26, 1892, the patient was anæmic but not emaciated, and her general condition remained satisfactory. The abdomen was voluminous. On abdominal palpation a median tumor was noted extending nearly to the umbilicus, the surface of which was smooth and regular, the consistence very hard and the dullness absolute. There was no ascites. To the touch the cervix was found to be very voluminous, hard, regular; the orifice was a little patulous. The neck, very much contracted, was continuous with a hard voluminous tumor, filling the cul-de-sac, and which appeared to occupy the body of the uterus and to lose itself in the mass observed by abdominal palpation. The mobility of the tumor was almost nil. Impulses communicated to the abdominal mass were transmitted feebly, but clearly to the uterine cervix. Chaput inclined to the diagnosis of salpingitis rather than fibroma, basing his views especially upon the considerable fixity of the tumor which did not appear immobilized by its volume, and because there were no symptoms of vesical or rectal compression. The urine was normal, cystitis did not exist, nor frequent micturition, nor was constipation present.

He decided to perform a laparotomy in preference to a vaginal hysterectomy, (1), because of the obscurity of the diagnosis; (2), because in case it were a fibroma, there

†Translated for THE MEDICAL AND SURGICAL REPORTER, by W. A. N. Dorland, M. D.



was a good chance of being able to perform castration, a simple, benign, and efficacious operation. The operation was performed and an enormous collection of pus found in the tube. This was aspirated with Potain's apparatus. It was very fetid, grumous, and amounted to about 250 grammes. A large quantity remained in the sac. During the process of enucleation of this sac, it ruptured into the pelvis; sponges, however, were placed to prevent inundation of the large peritoneal cavity. The sac being very sessile the membrane pedicle was divided into two portions, after which the sac was drawn out. It was then found that the tumor was strongly adherent to the pelvic colon, the adhesions being so intimate that they had to be severed by scissors. The sac was also adherent to the right side of the uterus and decortication left a large bleeding surface which rendered supra-vaginal amputation indispensable.

It was decided therefore, to do this, but after vertical section of the uterus through its entire length. This section presents the following advantages: the pedicle of the uterus is less voluminous, being divided; therefore more easy to treat. Moreover, the medium section being prolonged below, the vagina is opened and it becomes easy to establish an abdomino-vaginal drainage the employment of which is formally indicated on account of the issue of pus in the peritoneum. The total median section is followed by only an insignificant exudation of blood.

In the case quoted, to the left there existed a suppurating salpingitis up, the broad ligament cut between of small volume. This was drawn two forceps and upon the left uterine pedicle was placed a gum elastic ligature. The membranous pedicles were ligated with silk, the pelvic cavity cleansed with sponges soaked in carbolic acid of 21-20-0. Finally an abdomino-vaginal drainage was established. A smaller tube of large caliber, twenty cm. long, furnished with holes in its lower half only, was introduced by the abdomen down to the vagina, the latter having been disinfected before the operation. Two hemostatic forceps seize the lower orifice of the tube in the vagina without obliterating it. The upper extremity of the tube is traversed close to the abdominal wall by a sterilized English pin, then protected by

a dressing of iodoformized cotton. A little iodoform gauze is rolled around the forceps at the entrance of the vagina. Every six hours the abdominal dressing is removed and the tube irrigated with boiled water which escapes readily by the vagina. The tube is removed at the end of ten days and from this time a daily vaginal injection of bichloride is given. At the end of a month the elastic ligature comes away per vaginam, and the patient is completely cured.

By means of the abdomino-vaginal drainage, iodoform poisoning and stagnation are avoided. It may be mentioned here that the tube determines intestinal adhesions which constitute a sort of diaphragm which protects the peritoneal cavity. Chaput gives this operation the name of *Supra-vaginal amputation, with total median section and abdomino-vaginal drainage*.

#### Muscular Ruptures.†

Duplay (*La Méd. Mod.*, February 15) describes injuries of the muscles, the results of violent muscular effort, as of three kinds, viz.:—1, Luxation of the muscle; 2, Hernia through the aponeurosis; 3, Rupture of the muscle.

Luxation is a rather rare condition, and, in fact, is denied by some. Hernia consists in a tear of the aponeurosis with a protrusion of the fleshy substance of the muscle through the tear. This lesion is especially seen in the adduction of the thigh and gives rise to symptoms almost pathognomonic; there is a relaxation of the aponeurosis through which the muscle forms a hernial protrusion during contraction. There is also a change in the volume of the tumor according as to whether the muscle is in the state of contraction or relaxation.

Rupture of the muscle may be complete or partial. *Complete* rupture takes place most frequently at the union of the muscular and tendinous fibres, but, at times, it may occur in the middle of the muscle, especially in the biceps muscle. In *partial* rupture only certain bundles are involved; the separation between the two ends may be felt, especially at the upper end. If the muscle contracts the upper end protrudes considerably, while below there is a marked loss of substance

†Translated for THE MEDICAL AND SURGICAL RE-  
PORTER by W. A. N. Dorland, M. D.

noticed between the two divided extremities. These symptoms are difficult to observe when it is a deep muscle that is involved. On the other hand the diagnosis may be notably obscured by the production of an enormous blood effusion. Richardson has observed an effusion of at least a litre of blood. It might be conceived that the existence of an effusion of this kind might markedly hinder the correct diagnosis of rupture of a muscle. But in short this effusion itself, if it does not exceed certain limits forms part of the symptomatology. It always gives rise to an intra-muscular hematoma, which aids in the diagnosis. Finally there is a third variety. It is a rupture still more partial, we might say, a fibrillar rupture, in which the muscular rupture compared to the tear of the vessels, plays but a secondary role. The condition is nearly exclusively marked by the hematoma. There has indeed been a muscular tear, but this tear is fibrillar, but slightly extended, and the hematoma constitutes the essential element. If the hematoma is cured the muscular rupture will not give rise to any trouble.

In every case, in order to complete the diagnosis, it is necessary to ascertain whether, independently of traumatism, there exist other conditions that might favor the tear. At times there are found some very important predisposing causes, especially is this the case in individuals affected with grave infectious diseases. Then, under the influence of the muscular alterations noted by Hayem (granular and fatty degeneration), a very slight muscular contraction, such as is caused by the patient turning in bed, may give rise to a muscular tear. The great rectus of the abdomen on the right side is exposed particularly in this case; sometimes, as in typhoid patients, a tear of both recti may be observed. In these cases the hematoma nearly always ends in suppuration; whence a special variety of sub-aponeurotic abscess of the abdominal cavity may give rise to strange errors in diagnosis. In healthy individuals such is not the course, and suppuration is quite exceptional. Usually affairs rapidly change for the better. When the tear is not very extensive, so as to cause non-union, cure is usually very rapid. On the contrary, in infected individuals, suppuration frequently results.

There remains to be mentioned a last and very interesting termination; this is the persistence of the hematoma in the form of a tumor, generally small. It is a solid tumor; at times as hard as wood. If the initial traumatism is not known the most singular errors of diagnosis with every possible and imaginable tumor may be made. It is necessary, therefore, to think always of the possibility of these tumors. They may appear after a simple muscular contusion. It is necessary also to note especially in the lower limb a possible grave sequel. The muscular tear occurring in the lower limb is known, vulgarly, by the name of "*coup de fouet*." If varices, even latent, exist there may be produced, under the influence of the tear of the vessels, a venous thrombosis. If then a violent form of treatment be instituted, massage for example, embolism, even fatal, may be produced.

Treatment of incomplete or partial rupture with the formation of an hematoma. The first indication is absolute rest of the muscle. If possible it should be relaxed completely. Local applications: emollients at first (laudanum poultices, etc.) A little later, if the blood is slow in being absorbed, some revulsives may be given with a little compression. For the lower limb avoid massage for fear of embolism.

#### A Report of all the Laparotomies Performed in the Clinic of Prof. Billroth during the last Twenty-five Years.\*

Hansy and Dr. E. Knauer report 969 operations, not including those operations for hernia, extirpation of tumors of the abdominal wall, opening of the peritoneum, extirpation of the uterus *per vagina*—or operations on the rectum or bladder.

Cases	Recov.	Deaths	Total
Ovariectomies . . . . .	340	127	467
Myotomies . . . . .	83	65	148
Operations on the stomach . . . . .	55	54	109
"    "    Intestines . . . . .	48	38	86
"    "    liver spleen . . . . .			
and pancreas . . . . .	19	13	32
Operations on the kidneys and retro-peritoneal swellings . . . . .	9	15	24
Incisions . . . . .	63	32	95
Varia . . . . .	2	6	8

\*Translated for the MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

### Further Contributions to the Studies of Operation for the Removal of Goitre.\*

According to Dr. Ar. Eiselsberg, of Vienna, of the 52 operations for the *Total Extirpation of Goitre* at the Clinic of Billroth until July, 1892, 3 died suddenly (collapse, sepsis and entrance of air). The further results of the total extirpation were as follows: 12 suffered from tetanus, 11 from cachexia strumipriva, 10 made uninterrupted recovery (3 of these had no return; in 7 there was a return). The cachexia in one remained the same after as before the operation, and in 15 the results were either not known, or the time since the operation for reporting was too short. The author feels, therefore, that he can present the results, immediate and remote following this operation in 70 per cent. of the cases seen. Among the cases operated, there are 6 which do not correspond with our present views regarding the function of the thyroid gland. These are the 3 cases of cachexia with return of goitre, and 3 cases in which there is no return; all of whom remained well. He, especially, speaks of 12 cases done since July, 1885 to 1889, in which *more than four-fifths of the goitre was extirpated*. Of these, five died (1 from tetanus, 4 from collapse, sepsis and pneumonia); 4 patients subsequently suffered from tetanus but recovered later, much improved; 3 recovered entirely and remained so. *Partial extirpation in which at least one-fourth of the goitre was left*, was done 47 times with 42 recoveries. Mild symptoms of tetanus were noticed but in 1 case following the operation. *Enucleation of the goitrous nodule* was performed in 40 cases with 38 recoveries. *Ligation of the four arteries*, according to Wölfler, was performed 7 times for large diffuse struma, resulting in each case in contraction of the growth. In 3 cases the result was a very desirable one. Of particular interest is the report of one case in which acute suppuration of the thyroid gland was followed by tetanus, which had previously become colloid in nature and later took on sarcomatous degeneration. The author concludes from the results of these various operations that those cases in which a certain portion of the gland was allowed to remain—to continue to

functional activity—it became the means of controlling the graver complications.

### Contributions to the Studies of Carcinoma of the Thyroid Gland.\*

Dr. Hinterstoiszen, the author, has based his studies upon fifty cases of carcinoma of the thyroid observed by him, during the past years in the Pathological Institute of Vienna. Twenty-eight occurred among men, and twenty-two among women. In the majority of cases the tumors presented a large circumference. In several cases the primary infection was almost unrecognized in contrast to the metastatic swellings in distant organs. The capsule of the thyroid was usually found, even in large tumors, to be intact. Particularly interesting was the relation which this tumor bore to the neighboring organs, such as the larynx, œsophagus, the large blood vessels and the nerves. The integument was rarely found to be adherent. In contradistinction to the carcinoma of the other organs, in which the infection follows the lymph channels, the thyroid variety extends preferably along the blood channels. The implication and induration of larger venous trunks near this tumor was found in eleven cases. In thirty-five cases secondary deposits were found in the lymph glands; in twenty-nine cases metastatic centers were found in the lungs. In isolated cases metastatics were found in the liver, heart, kidneys, and brain substances, and in ten cases metastatics were found in the bony system.

Histologically the author divides it into three classes; first, the *adeno-carcinoma*, which he subdivides into two, (a) adeno-carcinoma with partial or entire follicular construction and with colloid formation; (b) the cylindrical cell, adeno-carcinoma.

Second, the *medullary carcinoma* which is the most frequent.

Third, the *fibrous carcinoma*.

In his closing remarks he speaks of the diagnosis as being exceedingly difficult in the earlier stages. Since a benign growth frequently takes on malignant degeneration, and the exact time of this change is impossible for any physician to know. The operative results have up to the present time been very unfavorable.—(*Schmidt's Jahrbucher*, Band 237, No. 1.)

\*Translated for THE MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

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## ABSTRACTS.

## THE SURGICAL THERAPY OF RECTAL CANCER.

Manley, of New York, gives (*Merk's Med. Bulletin*, Feb., 1893), the comparative values of the different operations for rectal cancer—tentative and radical—gathered from the published records of various surgeons.

In the London Hospital, from 1872 to 1880, thirteen colotomies for cancer were performed, with nine deaths. During the same time, says Cripps,\* 26 such operations were performed at Guy's Hospital with 11 deaths—a mortality of about 42 per cent. It does not appear whether this was an operative mortality, or whether those were simply classified under "mortality," who died before leaving the hospital. Allingham gives 27 colotomies with a mortality of 11 per cent.

Cripps, says of colotomy that in some it affords relief from pain, while in others it has failed to do any good. Of course, in complete intestinal obstruction, a colotomy must be done.

Of later years, in France, Pinault, Velpeau, Récamier, Massé, Chassaignac, Maisonneuve, and in Germany, Freinonze, Nussbaum and Schuh, revived the operation of rectal resection for cancer, and in England, Paget, Jordan, Holt, Allingham, Gray and Holmes gave it their support.

In Cripps's Jacksonian essay on 36 recorded cases of extirpation *per-rectum*, defæcation became normal in 23; could not be retained when fluid in six and incontinence continued in only seven.

In all cases it appears that incontinence is the rule immediately after operation, but as the wound heals control is regained. Retention of the fæces, however, is possible in many instances even after the entire sphincter has been cut away.

In another table of Cripps', we find, of 66 recorded cases of extirpation: 44 recovered and 11 died—a mortality of 17 per cent.

Préchaud's tables,† made up from his own cases and the records of several other operators, give 149 observations on

rectal cancer extirpations, of which there were 103 operative cures (69.13 per cent).

Immediate relapse in.....	3.
Doubtful results in.....	7.
Operative Deaths in.....	36.
69 relapsed after.....	1 year.
15 " ".....	2 years.
2 " ".....	3 "
5 " ".....	4 "
5 " ".....	5 "

Hence, from the above, we must assume that, five years after operation, none but six could be accounted for,—or about 4 per cent. of all.

Charron gives us a table of results in 139 cases of colotomy(\*). Of these,—

8 were missing and could not be accounted for.
54 died within 2 months.
65 lived from 2 months to one year.
5 lived from 12 months to 18 months.
3 lived from 1 year to 2 years.
6 lived 3 years or more.

It would appear from the above table that, in the results as far as prolongation of life is concerned, there is little difference ultimately.

It does not appear from these tables whether those who died, succumbed through a *local* recurrence of the malady, or as the result of a generalization or metastasis.

It is a matter of common observation that, when local, superficial epithelial growths are completely swept away by caustics or the knife, the disease most commonly recurs rather in the *internal viscera* than at its original site.

## THE QUESTION, THEN, TO DETERMINE,

in a given case of cancer, is *not*—"what operation will eradicate the malady"; for that is clearly quite out of the question;—but rather,—“which will afford a temporary cure, and give the patient the greatest amount of *mental quiet* and bodily comfort; so that, when the end comes, it may be painless”; as we know is commonly the case when death is due to cancer of the internal organs.

On the main points which the question involves, modern surgery has made possible a quite general accord of opinion among operators.

\*Cripps on Rectal Cancer; Ed. I., p. 212.

†Préchaud's "Cancer du Rectum," p. 126.

\*Charron: "Maladies du Rectum," p. 112.

## CURRENT LITERATURE REVIEWED.

THE AMERICAN JOURNAL OF OBSTETRICS  
FOR MARCH.

Dr. Jacob Rosenthal, of Dresden, contributes a paper on

## An Operation for the Cure of Vesico-Cervical Fistula by the Sectio Alta.

The operation was devised by Trendelenberg for the relief of those cases of vesico-cervical, vesico-uterine and certain vesico-vaginal fistulae in which, owing to the relations of the parts, the ordinary operation cannot be done; and is described as follows: "An extra-peritoneal suprapubic cystotomy is done, and after the bladder is opened the edges of the fistula are freshened and sewed; the bladder is then sewed up, leaving a small space for drainage; the abdominal incision is but partly closed, and the prevesical space tamponed with iodoform gauze and drained." In the case reported the patient, a primipara, complained after getting up that she was unable to hold her water. On examination the urine appeared to come from a slit-like opening between the bladder and the cervix high up in the vaginal wall on the right side. The anterior wall of the cervix had also disappeared and presented a funnel-shaped depression. It was impossible, owing to old and extensive adhesions, to operate *per vaginam*. The operation was performed by Prof. Leopold. The bladder was opened and found to contain a small soft stone which was removed. On further examination it was found that the fistula was high up on the right side of the bladder, opposite the descending ramus of the pubis, and that it communicated at this point not only with the uterus but also with the pubic joint by means of an irregular fistulous tract from which pus was oozing. An effort to freshen the edges of the fistula was found impracticable as the tissues had become too dense and adherent to the pelvis and there was little chance that the edges would unite. The urethra and ureters being beneath the fistula, a new bladder of reduced size was constructed by making a flap from the anterior wall of the bladder and another from the posterior wall, beginning beneath the fistula and approximating the two. The fistula was thus left outside the new bladder and was closed with catgut, an iodoform drain being introduced into the uterus. On exploring the fistulous tract leading to the pubic joint, the cartilage was found destroyed and the bones carious. The joint and fistulous tract were curetted. The patient made a good recovery. The literature of the subject is reviewed by the reporter and the paper is illustrated with cuts showing the condition of the bladder and the steps of the operation.

Dr. Paul F. Munde reports

## Seven Unusual Cases of Congenital Malformation of the Female Genital Organs.

After discussing the subject of malformation of the female genital organs the author reports the following cases:

I. Imperforate vagina; rudimentary uterus; absence of ovaries. An artificial vagina was made in the hope that the uterus and ovaries might be stimulated to a more natural growth. On reaching the rudimentary uterus in the dissection a discharge of thick mucous took place. The small uterus was about one inch long. The edges of the external os were stitched to the margin of the newly formed vagina and the whole cavity packed with iodoform gauze. No ovaries could be detected.

II. Perfect female habitus; normal genitals and vagina; rudimentary uterus; absence of ovaries.

III. Perfect vagina; absence of uterus and ovaries; normal female habitus. In these last two cases there was no relief to be offered.

IV. Double uterus and vagina; congenital closure of the right half; hematometra and hematocolpos dextra lateralis. The septum between the two halves of the uterus and vagina was excised from vulva to fundus. It proved very thick and vascular, and numerous catgut ligatures were required to stop the bleeding. The patient recovered fully.

V. Double uterus and vagina; normal ovaries; dysmenorrhœa. This patient had been advised to have the ovaries removed on account of the severe dysmenorrhœa. The whole septum was excised from vulva to fundus resulting in the cure of the dysmenorrhœa. Dr. Munde does not explain the relief from pain in this case.

VI. Double uterus; pregnancy in the left half mistaken for extra-uterine. Laparotomy was performed under the impression that an extra-uterine pregnancy existed, or an interstitial pregnancy in the right horn. In order to reduce the size of the tumor as much as possible, so as to bring it out of the small incision, the amniotic fluid was aspirated. The sound had previously been passed to a depth of three inches; but on requesting the assistant to again pass it, to the operator's surprise it entered to a depth of five and one half inches and was plainly visible through the uterine wall. On withdrawing the sound and on entering it on the left it only passed to the depth of three inches, proving the case one of double uterus. The patient aborted twelve hours later and made an uneventful recovery. "It would be well to consider the possibility of making this mistake in cases of doubtful pregnancy, particularly in those where the fetus is claimed to have been expelled through a dilated uterotubal opening into the uterine cavity and delivered as in ordinary abortion."

VII. Double uterus and double vagina; right half parous and containing fibroid, left half rudimentary. The patient had had two children. A fleshy fold divided the upper half of the vagina and had probably originally extended down to the vulva but had been torn away in one of the labors.

The paper is illustrated with cuts showing the conditions existing in each of the cases reported.

Dr. L. S. McMurtry, in an able paper on  
*The Essential Question of Drainage in Pelvic Surgery*

represents fully the views of those surgeons who are accustomed to use the drainage tube in their pelvic work. The objections to its use are also discussed and answered. After reviewing the principles underlying the use of the drainage tube and showing that incision, evacuation and drainage of an abscess are but limitations of nature's own processes, he gives the indications for its employment. "In operations where there is existing peritonitis or ascites, drainage" he says "is indicated. This is especially true of cases of tubercular peritonitis." He regards its use as essential in pus cases and in extra-uterine pregnancy where we have septic matter on the one hand, and an effusion of blood into the peritoneum on the other. In his experience he has saved patients by the drainage tube in cases where the coats of the bowel or the bladder had been injured and the resulting fistula developed through the drainage tract instead of discharging into the peritoneal cavity as it would otherwise have done. "Where separation of adhesions leaves extensive denuded surfaces oozing serum and blood, or bleeding is reasonably to be expected, the tube is indicated." If the tube be frequently emptied it has power to stop the hemorrhage by the frequent drying and cleansing of the peritoneum, and also will give notice to doctor and nurse of any serious bleeding. In regard to the method of draining he says "No method of drainage in pelvic surgery is comparable to the glass suprapubic tube aided by suction." It should be frequently cleansed by means of a long-nozzled syringe. When effusion is profuse the tube should be emptied at first every fifteen minutes, gradually increasing the interval as the quantity discharged diminishes. When peritoneal drainage is conducted in the proper manner it is thoroughly efficient, and he has never known septic infection to occur thereby. He does not include pelvic drainage *per vaginam* in the paper because he considers it both inefficient and dangerous—"inefficient because rubber and gauze will be obstructed, and glass is impracticable; dangerous for the reason that the tube and the opening cannot be kept clean."

Dr. Charles Dixon Jones contributes a paper on the

*Development of the Placenta in Tubal Gestation*

in which he comes to the following conclusions:

"1. In the earliest stages of the formation of the decidua, the folds of the tubal mucosa become enlarged, their connective tissue returns to protoplasm, their blood vessels become considerably dilated and engorged with blood.

2. Upon the approach of the decidua the columnar ciliated epithelia of the tubal mucosa enter upon a process of proliferation resulting in the production of medullary or embryonal corpuscles.

3. The medullary corpuscles are developed from previously existing columnar epithelia and in turn are transformed into decidual tissue.

4. The delicate fibrous connective tissue of the tubal mucosa is reduced to protoplasm, the stage of indifference from which decidual tissue originates.

5. The smooth muscle fibres of the tubal mucosa proliferate, produce medullary corpuscles much the same as the columnar epithelia and ultimately disappear by being transformed into decidual tissue.

6. In the third month of tubal pregnancy a lively new formation of placental villi takes place, first by a thickening, afterward by a budding-out of the older villi.

7. These buds are protoplasmic in nature and are identical in their structure with that of the epithelial layer which gave origin to them. At first the buds are non-nucleated; later on they become supplied with nuclei.

8. The originally solid buds become differentiated into a peripheral epithelial layer and a central connective tissue layer. The latter is at first made up of medullary or embryonal tissue, and afterward becomes transformed into myxomatous tissue.

9. The capillary blood-vessels grow into the central tissue by a sprouting of the older capillary loops. The sprouts are originally solid, and in turn become hollowed out by vacuolation, thus connecting with the older blood-vessels."

The paper is illustrated by cuts showing the conditions spoken of in the above resume.

Dr. James F. W. Ross reports a case of

*Complete Hysterectomy,*

being the second case of pregnancy complicated by fibroid tumor that has occurred in his practice within ten months. The patient was forty years old, had been married eleven months but had never been pregnant. Menstruation had been suppressed three months. She had noticed a lump in the side one month before the menstruation ceased, but it had never caused her any pain although it had increased to the size of a fetal head when the reporter saw her. The diagnosis made at that time was pregnancy complicated with either a multi-locular ovarian cyst or a fibroid tumor. At the operation it was found to be a fibroid springing from the left side of a four months pregnant uterus. Complete extirpation of the uterus was performed after the method advocated by Dr. Eastman. The tumor was drawn out; the broad ligaments tied on each side; a temporary clamp applied and the tumor cut away. An Eastman staff was then passed into the vagina and cut down upon from above through the cul-de-sac of Douglas. One finger was then passed into the vagina and the inter-abdomino-vaginal tissue sutured and cut; in this way removing the entire uterus. The ligatures were then caught together by a pair of forceps, passed up from the vagina, and drawn down together with a twisted rope of iodoform gauze. "The iodoform gauze and sutures were thus lying in the vagina, and the serous surfaces of the peritoneum surrounding the opening were approximated by this funnel-



ling of the hole where the cervix had been." The patient recovered from the operation but died on the thirty-ninth day of intestinal obstruction, during Dr. Ross's absence from home. The report is illustrated with a photograph of the tumor and fetus removed.

Dr. J. Wesley Bovee reports a case of "Complete Rupture of the Uterus during Labor." The patient had had seven children at term, and one miscarriage at three months, which occurred subsequent to an amputation of the cervix for cancer. On examination the child was found to be presenting by the vertex in L. O. A. position; the cervix uteri surrounded by undilatable, cicatricial tissue. It was decided to let labor go on and assist in whatever way seemed best. The pains continued feeble and the patient was kept in bed. Later profound and sudden collapse occurred and on examination the uterus was found to have ruptured. The post mortem showed the tear to be in the left side of the cervix posteriorly and extending from about an inch from the cervical opening upward four or five inches. "Connected with this opening was a tear through the roof of the vagina behind the uterus extending backward and to the right about two inches. The uterine wall was very soft and flabby, and its inner surface covered with a greyish, grumous material having no particularly offensive odor. No evidence of hemorrhage was found. The os uteri was very little dilated and was surrounded by a thin, circular band of cicatricial tissue." The reporter thinks the cicatrix, following the amputation of the cervix and the application of cautery, was the exciting cause of the rupture. He advises hysterectomy, either vaginal or abdominal, for cases of malignant disease of the uterus wherever it is possible.

Dr. Alfred Bland Tucker reports a "Case of Lumbar and Inguinal Hernia of the Right Side." The mass, weighing about forty pounds, extended from the umbilicus outward, corresponding with a line drawn from the axilla to the middle of the crest of the ilium, and reached to within three inches of the knee. The patient made a complete recovery from the operation. The points of interest in the case are: "1st, that there was a double hernia, the inguinal and the rarer lumbar; 2d, the contents of the sac—all of the small intestine, caput coli, part of ascending colon, and the stomach; 3d, the great displacement of the stomach from the epigastrium to a point below the crest of the ilium, and out of the abdominal cavity; 4th, the great elongation of the oesophagus necessary to reach that point; 5th, that there should not have been more disturbance of the digestive organs by the displacement." So far as the reporter is aware there is not on record a case of escape of the stomach in lumbar hernia. The engraving accompanying the report shows the patient's condition very clearly.

Dr. Sigmar Stark discusses the

Role of the Pessary in the Cure of Retrodisplacement of the Uterus.

The cause of the displacement he holds to be a relaxation of the sacro-uterine ligaments,

due to subinvolution of these folds, and being part of the uterine subinvolution. He believes that it requires more skill to properly adjust a pessary than to perform the many operations devised for the relief of the trouble. "To apply a pessary for retroflexion or version with coexisting peri-uterine inflammation of whatever character, is positive malpractice. The disease of the appendages must first be reduced, the organs rendered painless to the touch and the uterus become freely movable before recourse to the pessary may be taken." He believes the action of the pessary to be due to a pressure on, and consequent reduplication of, the sacro-uterine ligaments and gives the reasons for this belief. The aim should be not to apply a pessary till the patient is in a condition to wear one, to select a suitable instrument, and not to allow her to wear it too long. Some cases cannot be cured by the use of a pessary. In those in which the fundus is constantly tipping over the posterior bow of the pessary, we have an unstable condition of the fundus—a true joint at the junction of the cervix and the body due to atrophy. The second class of incurable cases are those in which there has been such atrophy of the folds of Douglass that restitution is out of the question and we have to be satisfied with the simple mechanical effects.

Dr. Hiram N. Vineberg concludes his paper on

#### Pelvic Massage in Gynecological Cases.

begun in the February number. He reports an additional number of cases treated by this method, illustrating the paper with drawings of the conditions existing in each case at the time of treatment. He comes to the following conclusions: "1. Pelvic massage is a most valuable therapeutic measure in a large percentage of cases of gynecological affections. 2. If properly applied in the cases where it is indicated, it is a thoroughly safe measure. 3. Cœliotomy and ventro-fixation for displacements of the uterus and for residua of inflammatory processes, are unjustifiable until the case has first been subjected to a thorough trial with pelvic massage. 4. It must entirely replace Schultze's method, which is a dangerous proceeding, limited in its application and not nearly as efficient in breaking up adhesions of long standing. 5. Of all methods and surgical procedures for the treatment of adherent and displaced pelvic organs, it must rank as the ideal one, calling for no mutilation and for no fixation of organs. The latter is in itself pathological, as Nature has given these organs, especially the uterus, a wide range of mobility."

Dr. E. W. Mitchell contributes a paper on

#### Rigidity of the Os Uteri.

The various causes of this condition are discussed and the following treatment advocated. Any malposition of the presenting part should be corrected. Dilatation by the finger may be useful at times, but care must be taken that the manipulation does not produce or intensify spasm of the circular fibres. The colpeurynter he considers much more

safe and efficient than the fingers, but must be used with the strictest antiseptic precautions. If the dilatation is prevented by adhesions between the membranes and the cervix, they can be released by gently sweeping the finger around the inner surface of the os. The use of ergot is condemned. Electricity, quinine in doses of ten to twenty grains, the hot douche, have all done good service in this condition. Opium is useful when the pains are weak and "teasing," by giving the woman rest and recuperating her powers. When it is not desired to stop the pains he has found of use chloral, administered after Playfair's rule of fifteen grains every twenty minutes for three doses, and not more than sixty grains during the labor. When chloral has failed to secure relaxation, chloroform inhaled during the pains may succeed. When a reasonable trial of other measures has failed, incisions of the rigid os may be made at several points, one-sixth to one-fourth of an inch deep, under antiseptic precautions.

Dr. Mary Almira Smith reports a case of "Malignant Neoplasm of a Lumbar Lymphatic Gland simulating an Ovarian Cystoma."

Dr. T. Ridgeway Barker discusses "The Mechanism of Labor," illustrating his paper with diagrams showing the positions of the head and shoulders in their passage through the pelvis.

#### THE ANNALS OF GYNECOLOGY AND PEDIATRY

for March contains a paper by Dr. Joseph Price on "Dermoids." The author reviews the recent literature of the subject and pleads for clean, rapid, thorough surgical work in their removal. Irrigation he considers essential. For tying the pedicle pure Chinese twist silk, as fine as possible, should be used. The sutures should be of silkworm gut, placed three or four to the inch and passed with care, including more aponeurotic and muscular tissue than skin or peritoneum. The best work is done with the fewest instruments.

Dr. B. F. Baer reports a "Large Solid Tumor of the Ovary, complicated with Malignant Disease of the Uterus." The diagnosis at first was fibroid tumor, though Dr. Baer suspected malignancy. At the operation it was found to be a solid tumor of the ovary with accompanying malignancy of the uterus. A supra-vaginal amputation of the uterus was done, and twenty days later the stump of the cervix removed by a vaginal operation. The patient recovered.

Dr. T. Ridgeway Barker discusses "The Coagulability of the Blood in Parturition as a Factor in the occurrence of Post-partum Hemorrhage." Post-partum hemorrhage is due to the non-contraction of the uterus and the failure of the blood to coagulate in the uterine sinuses. The author points out that should the blood escaping from the vulva during labor fail to coagulate on exposure to the air, we may take it as a warning that the patient is exposed to the danger of hemorrhage.

Fresh air and sunshine and judicious exercise during pregnancy, combined with good food are, in the author's opinion, important in the prevention of the accident.

Dr. Andrew F. Currier contributes a paper on "Certain Forms of Septicæmia Resulting from Abortion," which was published in the *MEDICAL AND SURGICAL REPORTER* Feb. 11, 1893, page 214.

Dr. A. T. Cabot presents

#### A Report of Cases of Tubal Pregnancy, with Remarks on the Choice of Operation.

He confines his remarks to cases of ruptured tubal gestation, as they have been the only form he has met with. He is of the opinion that laparotomy done at once, even in cases where no rupture has taken place, is a much safer method than any of the so-called conservative measures. When rupture has taken place there is manifestly one course only—laparotomy. No time is to be lost; a knife and ligatures are practically the only instruments required, so that the operation can be performed with simply a pocket case if necessary. "If the clots cannot be satisfactorily washed out of the abdomen with hot water, it is well to introduce drainage into the pelvis for a day or two." He then reports four cases with typical histories; three of which had had a miscarriage some time previous to the tubal gestation, and one who had a long period of sterility (six years) before the occurrence of the accident.

Very interesting in this connection is the report of a

#### Case of Extra-Uterine Fœtus Successfully Extracted by the Operation of Lithotomy,

reported by Dr. Joseph Bossuet, and contributed by Prof. T. Gaillard Thomas from the author's original manuscript. The case, which occurred in 1807, presented all the symptoms of missed labor which were controlled by large doses of opium. At the roll of three years she experienced acute pain in the abdomen, attended with profuse evacuations from the urethra of very fetid yellow matter and some very small bones. A communication between the bladder and rectum also developed. In 1816, lithotomy was performed and 146 bones of a fœtus, about seven months old, were extracted together with "a stone about the bigness of an olive." The author states that she then regained her health although the communication between the bladder and the rectum did not entirely close.

Dr. J. J. Mulheron makes a plea for "Early Trachelorrhaphy," stating that the operation at the end of two weeks is exceedingly easy of performance, and that he has not found it necessary to etherize the patient as no cutting is required but simply the freshening of the surfaces with a curette. The stitches are easily passed with a round needle through the soft tissues, and a peculiarity of the early operation is that it leaves no traces of the sutures. He uses carbollised catgut and has not yet met with a failure. The procedure hastens involution and is preferable in his opinion, to the immediate operation which he has found very difficult of performance.

Other papers are: "Variations of Gestation" by Dr. T. C. Hays; and "Pelvic Inflammations following Parturition" by Dr. J. G. Biller.

In the Department of Pædiatry, Dr. J. Madison Taylor reports a "Case of Hypospadias; Enormous Dilatation of Bladder; Absence of Left Kidney; Death" illustrating the paper with the photograph of the patient.

Dr. W. Henry Price reports a case of "Sarcoma in an Infant," and "Two Unusual Cases of Torticollis" of rheumatic origin which are exceptions to the rule that the head is drawn to the affected side.

#### PRACTICE FOR FEBRUARY.

Drs. Hugh M. Taylor and Hunter McGuire report an interesting case of  
**Ectopic Gestation.**

Dr. Taylor diagnosed the case and urged the importance of operation. During the conversation the patient complained of sudden agonizing pain and went into a collapse. One hour and a half later Dr. McGuire opened the abdomen, found the ruptured tube, ligated and removed it, but the patient had lost so much blood that she did not rally. Dr. McGuire believes that she bled to death in about thirty minutes. He urges the importance of operation as soon as the diagnosis is made. Mr. Taylor in his remarks on the case agrees with Dr. Tait that all ectopic gestations are primarily tubal, and that the so-called ovarian, abdominal, etc., are secondary results. But let the ectopic gestation occur where it may, the indications for treatment are the same. He thinks "that temporizing with electricity savors of shirking one's duty. To shoot a few flashes of electricity through an unknown mass claiming to have electrocuted a tubal fetus, implies a very elastic imagination or conscience."

Dr. John Blake White contributes a paper on

**Pneumotomy for Relief of Tubercular Abscess and Gangrene of the Lungs,**  
reporting a case where the operation was performed twice on one patient, with recovery.

He condemns too diligent washing out of pus cavities, pulmonary or pleural, though he believes that irrigation is safer in gangrenous cavities, as in the case reported, than in those emitting more laudable pus. In all operations on the lungs the strictest antiseptis should be carried out. Cases of gangrene of the lung are never too far advanced for surgical interference, in his opinion. He does not consider it necessary to excite pleural adhesion before operating, as the delay required may increase the danger to the patient. Resection of the rib is seldom required in the very young, except to facilitate the discovery of abscess in doubtful cases. Corrugated white rubber tubing was used for drainage, as this has proved more useful than the ordinary soft rubber generally employed.

Dr. Thomas H. Manley, in an article on

**Urethrectomy, Partial or Complete, as a Method for Radical Treatment of Rupture of the Urethra, Fistula, or Organic Stricture,**

comes to the following conclusions: In all cases of traumatic rupture of the perineal urethra, the tissues should be laid open at as early a date as possible, and the continuity of the lumen of the urethra should then be entirely restored by a urethrorrhaphy. Those urethral perineal fistulæ which resist dilatation or other tentative measures, should be resected and continuity restored in the passage by homologous approximation of the separated edges, the hiatus remaining being obliterated through linear elongation of the fibres of the muscular coat. With those strictures rebellious to tentative methods, not appropriate for internal urethrotomy or division, when they are divided by an external incision, the occasion should be utilized to hew a gutter through the cicatricial tissues, and to reconstruct the floor of the canal with the adjacent connective tissues. In all cases the most rigorous asepsis should be employed, and the aim, in every case, should be to secure non-suppurative, primary union.

The remaining article is a clinical lecture by Dr. Robert T. Morris on "The Middle Scar Hair-lip operation, and Dupuytren's Contraction."

## SELECTED FORMULÆ.

### Laundry Starch Polish.

In answer to a correspondent the *National Druggist* gives the following information about laundry starch polish:

**R** Starch..... 25 parts  
Spermaceti..... 200 parts  
White wax..... 100 parts

Melt together, and while melted stir in  $\frac{1}{4}$  grain of ultramarine to each ounce of the mixture. (As liquid blue is used with most starches the latter may be omitted.) Let cool and cut into little blocks weighing about 2 ounces each. One of these bits may be added to each  $\frac{1}{4}$  pound of starch used. The starch may be allowed to boil for fifteen minutes before adding the gloss, and the boiling should be continued for at least five minutes longer.

### Gonorrhœa in Females.

Dr. Horwitz recommends the following treatment:

**R** Ung. cucumis..... ʒj  
Alum..... ʒj  
Acid. tannic..... ʒij M.  
Ft. unguentum

Smear a quantity on a pledget of cotton, pass it into the vagina at night; remove it in the morning, and use the following injection:

**R** Decoct. quercus alb..... Oj  
Sodii boratis..... ʒss M. —Ex.



**Vomiting in Pregnancy.**

Dr. Frank R. Fry recommends the following:

<b>R</b>	Cocain. muriat.....	grs. vj.
	Ceril oxalat.....	grs. xxiv.
	Glycerine,	
	Aque laurocer, }	ss.
	Aque destil. q. s. ad.....	℥ij.

M. Fiat mist. Sig.—One tablespoonful (taken cold) every two hours once or twice a day, pro re nata.

—*Coll. and Clin. Record.*

**Sore Throat.**

The following is recommended in the treatment of sore throat:

<b>R</b>	Cocaine hydrochlorat.....	grs. viij.
	Acid. carbolicl.....	℥i.
	Glycerine.....	℥ssiv.
	Aque rosae q. s., ad.....	℥xii.

M. Sig.—To be diluted with an equal quantity of water, and used alternately as a spray and gargle.

—*Medical Progress.*

**Local Psoriasis.**

Pyrogallie acid, salicylic acid, chrysophanic acid, ichthyol, aristol. each ℥j; axonge, ℥ss. To be applied once a day.

—*Med. Press and Circuit.*

**Barber's Itch.**

<b>R</b>	Tannic acid.....	45 grains.
	Lac sulphur.....	1½ drachms.
	Zinc oxide } of.....	
	Starch.....	4 drachms.
	Vaseline.....	1 ounce.

Make into an ointment and use twice daily.

—*Phar. Era.*

**Antiseptic Dental Cream.**

H. L. Hurxthal has been awarded a prize by the *Pharm. Record* for the following formula:

<b>R</b>	Precipitated chalk.....	5 drams.
	Powdered white castile soap.	1 dram.
	Salicylate of soda.....	30 grs.
	Oil of rose geranium.....	4 drops.
	Oil of wintergreen.....	4 "
	Solution of carmine.....	2 "
	Glycerine, 4 }	
	Water, 1 }	q. s.

**Tanifuge for Children.****—ELECTUARY.—**

<b>R</b>	Male fern extract.....	4 gms [1 dram]
	Calomel.....	0.3-0.4 gm [6grs.]
	Powdered gelatin	sufficient quantity of each]
	Powdered sugar	

For one electuary. To be taken before breakfast.

(The day preceding the administration of the medicament, the child should take nothing but milk; in the evening of the same day an enema of Senna Infusion is given, followed a few hours later by an injection of plain water. The next day, the child takes the confection. If the expulsion of the worm is tardy, a salt-water clyster is given (Salt 40 grammes [10 drs.], Water 200 grammes [6½ fl. oz.]) two or three hours after the ingestion of tanifuge.

—*Ex.*

**Treatment of Gonorrhœa.**

The following will be found useful:

Salol, ℥iv. Divide into twelve powders; three daily. Ichthyol, 1; water, 100. Three injections daily. Ichthyol is found to be superior to sublimate or permanganate of potass.

**Treatment of Impetigo Contagiosa.**

Besnier's application in impetigo contagiosa and pustulous exzema is as follows:

<b>R</b>	Salol.....	3 gm.
	Sulphuric ether.....	3 gm.
	Cocaine hydrochlorate.....	20 cg.
	Collodion.....	20 gm.

Mix and make a collodion. Apply to the diseased parts after carefully drying same

**Pomade for Psoriasis of Scalp.**

Besnier gives the following:

<b>R</b>	Potash soap.....	20 gm.
	Vaseline.....	20 gm.
	Ichthyol.....	2 gm.
	Salicylic acid.....	1 gm.
	Pyrogallie acid.....	1 gm.

Mix and make a pomade, which is to be applied every day to the plaques of psoriasis. If much irritation is created, suspend the application temporarily.

—*Nat. Druggist.*

**Soothing Syrup without Opium.**

<b>R</b>	Oil anise.....	mxiv.
	Alcohol.....	℥ij.
	Fl. ext. valerian.....	℥i.
	Oil peppermint.....	mxv.
	Tinc. camphor.....	℥ij.
	Fl. ext. liquorice.....	℥i.

M. Sig.—Shake the bottle. Dose, one-fourth or one-half teaspoonful in water; repeat as needed.

—*Med. Age.*

Prof. Hare recommends the following prescription in cases of *Gastralgia*:

<b>R</b>	Tinct. capsic.....	℥ij.
	Tinct. cannabis indicæ.....	℥ss.
	Tinct. opii deodorat.....	℥ij.
	Spirit. chloroform.....	℥ss.
	Spirit. lavender, q. s. ad.....	℥ssiv.

M. Sig. Teaspoonful every thirty minutes until relief is obtained.

**Vesical Injections of Emulsions of Iodoform in Purulent Cystitis.**

Dr. Philippoff (*Deut. Med.-Zeit.* No. 88, 1892) has used vesical irrigations of an emulsion of iodoform in the treatment of purulent cystitis, and is gratified with the results obtained in three severe cases. He first washes out the bladder with a solution of lactic acid (1:400), and then injects twenty grammes (5 drachms) of the following:

<b>R</b>	Finely powdered iodoform.....	gms. 5 (½℥j)
	Mucilage of gum arabic.....	gms. 2 (gts. xxx.)
	Pure Glycerine.....	gms. 8 (℥ij.)
	Distilled water, ad.....	50 gms. (℥ss.)

The injection is retained for fifteen minutes. They are repeated at intervals of several days, and continued for a number of weeks. Internally salol and Vichy water are given. With this treatment Philippoff had observed no symptoms of poisoning, due, he says, to the vesical mucous membrane being changed by the pathological process.

## PERISCOPE.

### MEDICINE

#### Heat in Local Skin Diseases.

Stepanaw (*St. Petersburg Medicinische Wochenschrift*), writes the following as the outcome of his investigations:

1. In the treatment of local skin diseases and ulcers, heat is an important factor.
2. Ulcers heal more rapidly in consequence of the application of heat than under any other treatment.
3. Heat acts as well upon syphilitic as upon non-syphilitic ulcers.
4. The beneficial effects of heat on the healing of ulcers depends principally upon regulating the circulation and improvement of the nutrition of the diseased parts.
5. Under the influence of heat, local congestion rapidly disappears.
6. Heat acts as a sedative.
7. Heat acts the better the longer it is applied (6 to 8 hours daily).
8. The application of heat by means of the rubber bag with hot water, is preferable to other methods. Even prolonged use of the bag does not produce blistering.—*Medical Era*.

#### Varicose Ulcers.

EUROPHEN.—Gilbert (Reprint from *Bal-neologisches Centralblatt*, Vol. II, No 13), reports two cases of varicose ulcers treated with euophen.

I. Woman aged sixty-nine. Hard infiltration and eczematous inflammation of entire left foot and leg; ulcer the size of a human palm, covered with flaccid, torpid granulations. All previous treatment proved ineffectual.

II. Woman aged fifty-five. Ulcer 4 cm. (1½ inch) long by 3 cm. (1¼ inch) broad, entirely surrounded by inflammatory indurations; varicose veins near the ulcer.

Treatment.—Local bath of chamomile flowers in the evening, sprinkling the entire surface with euophen, light covering with gauze and cotton-wool, and enveloping with muslin bandage. In the morning application of euophen ointment.

R. Euophen..... 2.0 (3 ss)  
Vaselin.....  
Lanolin..... aa 50.0 (3 xii ss)

M. f. ung.

This application was again covered and the leg bandaged. Soon healthy granular tissue appeared in both cases, and in three weeks the ulcers were covered with skin. There was no recurrence of the ulcer in either case.—*Gmn. Med. Jour.*

### SURGERY.

#### How to Administer Chloroform Properly.

Mr. W. J. Cleaver gives the following valuable advice in regard to the administration of chloroform: Take your folded towel or cap

of flannel stretched over a wire frame, and your chloroform bottle, graduated if you like, but this is of no consequence: let the temperature of the operating room be at least sixty-five degrees F.; if your patient be one of the very nervous kind, give from half an ounce to an ounce of brandy an hour beforehand; put your catch forceps or your tongue forceps on the pillow beside you; pour a dose of chloroform, a drachm or two, on to the towel or cap and hold it, to commence with, two or three inches away from the mouth and nose of your patient, gradually bring it nearer, but never so near as to exclude air from mixing with the chloroform vapor; at the same time keeping your mind and eye on the respiration movements alone. If the patient shows any symptoms of struggling, let assistants take hold of his wrists and allow him to move his arms about as long as he does not interfere with the administration. If he endeavors to get up he must, of course, be restrained, but on no account let half-a-dozen dressers throw themselves upon him, their united weight probably coming near upon half a ton. What chance has free respiration in such a case? A little pressure on the shoulders will in ninety-nine cases out of a hundred be found to be quite sufficient; when a patient is forcibly held down with half a dozen big men on top of him, his struggle ends in a kind of night-mare, with perhaps a fatal shock at the close of it. Continue the administration quietly and gradually, without being put out of countenance by the repeated demands of the operator—to know whether he is not yet under; and such remarks as, I never knew a man take such a lot, put it closer to his nose, what a time he is getting under, etc., etc. You are giving the chloroform, not the operator, therefore take no heed of him. When there is no conjunctival reflex, and a pinch on the skin of the abdomen bears no result, the pupil of the eye fairly contracted, and the breathing regular but perhaps stertorous, you can allow the operating surgeon to proceed.

Pay no attention to the operation, however interesting it may be; watch your patient's breathing only, and continue the chloroform when you see any signs of returning consciousness. If you do this, and this only, you will never have cause to regret it.—*Sheffield Med. Jour.*

#### Carbolic Acid in Surgery.

There is considerable excitement in surgical circles just now owing to the recantation of Sir Joseph Lister in regard to the use of carbolic acid and mercuric salts in surgery. He has now abandoned the latter entirely, and has gone back to the former. The fact was mentioned in *The Chemist and Druggist* a few months ago (November 5, 1892, page 681), but the medical papers have just got hold of it through an address delivered by Sir Joseph at King's College the other week. It seems that the reason why corrosive sublimate began to displace carbolic acid was be-

cause Koch made some observations which showed that the former was more powerful than the latter; but it turns out that Koch exaggerated the power of the sublimate, and in such solutions as can be used in surgery it is much inferior to the acid in bactericidal power. Professor Crookshank has made experiments with the two antiseptics upon the tubercle bacillus, which further demonstrate the superiority of carbolic acid. So much for what may be called the theory. In practice Sir Joseph Lister uses a 1-in-20 solution of carbolic acid, and he states that while "it is more trustworthy as a germicide for surgical purposes than corrosive sublimate, it is in other respects also greatly to be preferred. Carbolic acid has a powerful affinity for the epidermis, penetrating deeply into its substances, and it mingles with fatty materials in any proportion. Corrosive sublimate solution, on the other hand, cannot penetrate in the slightest degree into anything that is greasy; and therefore, as the skin is greasy, those who use corrosive sublimate require elaborate precautions in the way of cleansing the skin—treating it with oil of turpentine or ether, not to mention soap and water, to remove the grease which they feel it essential to get rid of for the efficient action of the corrosive sublimate. All this is unnecessary care if you use carbolic lotion." It is satisfactory to note that the founder of Listerism has gone back to his old faith. It deserves to be mentioned that for several years the quantity of corrosive sublimate used in the principal hospitals of London has been on the decrease, and carbolic acid has been taking its place. The reason for this has not been exactly that put forward by Sir Joseph Lister, but the fact that mercurial poisoning was becoming very frequent amongst surgical patients. This was due, of course, to the corrosive sublimate being pushed too far, as, indeed, antisepticism is apt to be. There is a growing belief that asepsis rather than antisepticism will hold the surgical field in the future.—*The Chem. and Druggist.*

#### Suture Applied to Wounds of Veins.

Dr. Max Schede (*Einige Bemerkungen ueber die naht von Venenwunden Arch. fur. Klin. Chirurgie* No. 3-4, 1892,) favors the application of a fine continuous catgut suture to wounds of the larger veins. He presents the case of a man who was operated upon for a malignant tumor of the kidney. During the operation the inferior cava was accidentally incised. The opening was closed by a suture that extended along the vessel for a distance of two inches. During the vein suture the hemorrhage was controlled by applying catch forceps above and below the opening and extending the vein.

The patient died several days after the operation, permitting an examination of the vein to be made. The intima had united firmly and the neighboring part of the vessel wall was perfectly normal. No evidence of thrombosis was present throughout the vessel. The author thinks suture much superior to ligature or leaving forceps upon the vein.

#### Two New Local Anæsthetics.

The muriate of tropa-cocaine, or tropain, is a substance obtained from the Java coca, and said by Professor Schweiger to have a local anæsthetic action resembling that of cocaine. It is weaker in action, but it causes anæsthesia more rapidly.

Eugenol-acetamide is recommended as a new anæsthetic. As crystallized from water it occurs in lustrous scales; from alcohol it occurs in fine needles, melting at 110° F.

This compound, when applied in the form of a fine powder, produces local anæsthesia without any caustic action, similar to cocaine. This anæsthetic effect, in connection with the strong antiseptic properties of eugenol-acetic acid, secures a place for this new amide in the treatment of wounds.—*N. Y. Med. Rec.*

#### OBSTETRICS.

##### A Bacillus of Eclampsia.

The time-honored relation of albuminuria to puerperal eclampsia—as cause and effect—has been questioned at various times, but as there had never been any facts presented which furnished a more plausible solution of the etiology of this serious disease, it has remained practically as before—the result of the nephritis of pregnancy.

Kaltenbach and Gerdes (*Wien. Med. Blaett., and Med. Deutsche Med. Wochen.*), and abstracted by The Review of Insanity and Nervous Diseases, have discovered a short, thick bacillus in the organs and blood of patients dead of puerperal eclampsia, and Gerdes sums up as follows:

1. The eclampsia bacillus is the sole cause of puerperal eclampsia and is found in no other disease, and there can be no eclampsia without its presence. The infection proceeds from the uterus, probably from an endometritis existing prior to conception.

2. The convulsions due to other causes occurring during labor, are to be strictly separated on the basis of the post-mortem appearances, from true puerperal eclampsia.

3. Eclampsia is a well-characterized disease, strictly limited anatomically.

4. The profound changes found in the organs of eclamptic patients *post mortem* are not adequately explained by the demonstration of the presence of the specific germ in the body, but are probably due, directly or indirectly, to its toxins.—*Chicago Clin. Review.*

#### Excursions to Washington.

Personally conducted tours to Washington have been arranged via Royal Blue Line, to be run at frequent intervals from New York and Philadelphia to Washington. The next excursion will be on April 6th. For programme, describing these tours, write to Thos. Cook & Son, Agents B. & O. R. R., 261 and 1225 Broadway, New York, or 332 Washington Street, Boston, Mass.